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A Grounded Theory Analysis of Hospital-based Chinese Midwives' Professional Identity Construction

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Thesis presented in fulfilment of the requirement of the degree
of Doctor of Philosophy

THE UNIVERSITY OF EDINBURGH

2013

DECLARATION

I hereby declare that this thesis has been composed by me and that the research on which it reports is my own work. No part of this thesis has been submitted for any other degree or professional qualification.

Jing Zhang

A handwritten signature in black ink, reading "Jing Zhang". The script is cursive and fluid, with the first letter of each name being capitalized and prominent.

ABSTRACT

Background: The professional development of midwifery in China has been challenged by its marginalised professional status and the medical dominance within midwifery practice in the contemporary maternity care system. There has been growing confusion about, ‘Who the midwife is and what does the midwife do?’ within and outside the profession. The sense of identity crisis for the profession has become particularly salient when Chinese midwifery becomes a sub-branch of the nursing profession during the contemporary period. If, however, we consider the International Confederation of Midwives (ICM) Mission Statement (2008: 32) that midwives are the ‘most appropriate professionals for childbearing women in keeping childbirth normal’, then the focus on a greater understanding of midwives is needed. It is the aim of this research to facilitate this understanding by exploring how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system and the factors that significantly influence the process.

Design and Method: A Constructivist Grounded Theory (CGT) study was conducted to achieve the research aim. A sample of 15 midwives and 5 women participants was recruited between October 2010 and May 2011 from a capital city in one province of China. The accounts from the participants in the form of in-depth individual interviews were digitally recorded and three work journals from midwife participants were also included to facilitate the exploration of the study subject. NVivo 8 was used to assist with data management for the analysis.

Findings: Six principle categories were identified: ‘institutional position’; ‘organisational management’; ‘professional discourse’; ‘compromising strategies’; ‘engaging strategies’; and ‘hybrid identity’. The integration of the principle categories has developed the theoretical model ‘navigating the self in maternity care’, which suggests that professional identity construction in midwives is a dynamic process, involving a constant structural and attitudinal interplay between

the external ('obstetric nurse') and internal ('professional midwife') definitions of the midwife. The model indicates that the midwives' professional identity construction was contextualised in their 'institutional position' in the contemporary maternity care system. In everyday practice, midwives experienced identity dissonance in relation to two competing identities: the 'obstetric nurse', bound up to the 'organisational management' in hospital settings; and the 'professional midwife', associated with the 'professional discourse' in the midwifery profession. Two types of strategies were identified to reduce the identity dissonance – 'compromising strategies' and 'engaging strategies' – which resulted in a 'hybrid identity', as the construction of professional identity in individual midwives is navigating along an identity continuum with 'obstetric nurse' and 'professional midwife' at opposing ends.

This thesis has expanded on the current theoretical knowledge of identity work by elaborating on the discursive practices professionals employ to legitimate their professional identity and the various strategies individuals use to negotiate their identities at work. It has also extended attention to the influence of institutional forces on professional identity construction. With specific regard to Chinese midwifery, this emerging theoretical model provides a number of possible implications for midwifery practice, education and policy which would facilitate the exploration of effective operational processes for midwives in China to develop professionally.

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CHAPTER ONE: INTRODUCTION

1.1 Introduction

Midwifery is frequently referred to as one of the oldest professions in the world. However, this profession has also been involved in a constant debate about how to define itself (Annandale and Clark, 1996), and what constitutes practitioners' professional identity (Davis-Floyd, 2007, Lane, 2002, Hunter, 2004). In China, midwives have over the course of time, been referred to as 'traditional midwives' (*jiē shēng pó*), 'modern midwives' (*zhù chǎn shì*), 'obstetric nurses', and even confused with the idea of 'doulas' (Cheung, 2009, Harris et al., 2009). Accompanying the ups and downs in the development of Chinese midwifery, the professional identity of midwives has adapted to changes. There has been growing confusion about, "who the midwife is and what does the midwife do?" within and outside the profession. The sense of identity crisis for the profession has become particularly salient during the contemporary period of Chinese midwifery. This formed the basis of the research inquiry for this thesis. This chapter first introduces the research problem based on my own personal reflections. The context for the study is followed. The aim of the study is then presented in conjunction with the research questions. The organisation of this thesis is listed at the end.

1.2 Personal Reflections on the Research Problem

Initially, the motivation for conducting this study was based on my own experience attending several midwifery conferences and having informal conversations with my friends who are midwives. It was disturbing to learn about the unfavourable institutional environment for midwifery in China, whereby there are no specific legal rules and the statutory body specifically for midwives, and the title 'midwife' is not recognised by legislation. Obstetricians have taken over the midwives' role during the birth process, whilst midwives are assigned to the nursing group. The previous conversations with midwives occurred to me during my time undertaking

research within a maternity unit. In this hospital, the obstetricians took on many of the roles previously performed by the midwives, even the delivery of low-risk labouring women.

Under such circumstances, midwives expressed that it was difficult to find a role for themselves in the current maternity care system. Therefore, the question “Who am I as a midwife and what should I do?” arose for midwives. This situation left me wondering how Chinese midwives perceived themselves as a midwife. More specifically, what was their professional identity and how did they construct it?

1.3 Context for the Study

When designing this study the literature related to professional identity in both the midwifery context and the broader disciplines was examined. Compared to the diverse dimensional research on identities within other professional disciplines (such as teaching, social work and other health professions), only a few studies in the midwifery literature have been specifically engaged in this topic. Findings from previous midwifery studies in other countries provided insight into the influential issues regarding the construction of midwives’ professional identity. However, when locating this topic within the context of contemporary Chinese midwifery, its marginalised professional status (particularly its currently subsumed position in the nursing profession) and the medical dominance within midwifery practice characterised its own background for Chinese midwives to construct their professional identity.

Ever since the policy of reform and opening up in the 1980s, the medical model symbolised by the belief in modernity has become dominant in the Chinese maternity care system; leading to the medicalisation and hospitalisation of childbirth throughout China (Barclay, 2008, Cheung, 2009). As a consequence, midwifery practice has been placed within a maternity care system dominated by the medical model; whilst the sphere of midwifery practice has been confined to

hospital settings and the majority of the hospital midwives' practices have been narrowed down to intrapartum care (Cheung, 2009, Harris et al., 2009). Hospital based Chinese midwives are in a state of struggling to establish their own professional boundaries with obstetricians and sustaining their professional identity (Cheung, 2011). A sense of identity crisis for the midwifery profession has emerged. This identity crisis has been aggravated in contemporary times, when the role of the midwife was marginalised by obstetricians and nurses and midwifery was categorised as a subset of the nursing profession (Cheung, 2009, Harris et al., 2007, Tan, 2010).

Considering the specialty of midwifery care, such categorisation and division of labour of the profession in the maternity care system has sparked concerns from the midwifery scholars and clinical midwives within and external to China (Cheung, 2009, Harris et al., 2009, Tan, 2010). To maintain the uniqueness of the midwifery profession in China, it is essential to clarify its theoretical basis in order to establish a clear professional boundary with other professions. The midwifery model is emphasised in this respect, which is expected to shape professional practice for the revival of natural childbirth in China and enable midwives to clarify and secure their own professional identity (Cheung et al., 2009, Mander et al., 2010). The midwifery model, also known as the social or humanistic model, has been constructed to define the unique role of midwives worldwide (ICM, 2011a, Walsh and Steen, 2007). Yet, in China this theoretical basis for midwifery practice remained mainly at the academic level in the research community and has been largely constrained under the regulation and practice of the medical model (Cheung et al., 2009). In this case, professional identity crisis would continue to be a problem if midwives are either not clear about the theoretical underpinnings of their professional role or unable to enact them in practice. Set against this identity crisis for contemporary Chinese midwifery, there is a need to examine how hospital-based Chinese midwives construct their professional identity in relation to the institutional forces, the working context and their individual beliefs.

1.4 Research Aim and Questions

This study has set out to explore how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. As a collective discourse on the profession, the constructs employed by midwives to define their professional identity have been identified. The process through which individual midwives construct their professional identity in hospital settings, along with the factors that influence this process, has been explored. By understanding the meaning-making process in one's professional identity construction and the influential factors, midwives may gain a better position to pursue their professionalisation in serving women and society.

Adopting a constructivist grounded theory approach, the broadly-stated research questions that I sought to answer for this study were:

- What constructs are drawn on by hospital-based midwives to define their professional identity?
- How do midwives construct their individual professional identity in hospital settings?
- What factors contribute to the construction of individual professional identity in hospital-based midwifery practice?

1.5 Organisation of the Thesis

Chapter One introduces the study. The aim and research questions are provided along with my own personal reflections on the research problem and an overview of the research context.

Chapter Two reviews the historical and political background of Chinese midwifery. The key aspects of the context for the professional identity construction of hospital-

based Chinese midwives are examined. By locating the research problem in its historical and political context, this chapter provides the foundation for the study.

Chapter Three provides an analysis of the literature pertaining to the theoretical context for this study. Included in this chapter is a critical review of the theoretical underpinnings of the published studies on professional identity and the issues pertaining to professional identity in the existing midwifery literature. Analysis identifies a gap in the existing knowledge of professional identity in Chinese midwives and the research focus is thus developed.

Chapter Four illustrates the research design for this study. It discusses the rationale for choosing constructivist grounded theory and provides a detailed description of the data collection, management and analysis processes. Ethical considerations, the quality and limitations of the study are also considered.

Chapter Five to Seven presents the findings and analytic discussions of the data through the use of a 'paradigm' framework (Strauss and Corbin, 1998: 123) to develop an understanding of how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. Chapter Five examines the category '*institutional position*', which epitomises the 'contextual condition' of midwives' professional identity construction in terms of their midwifery status at the institutional level. The analysis of the categories '*organisational management*' and '*professional discourse*' follows in Chapter Six, representing the 'causal condition' of midwives' professional identity construction in terms of the conflicting ideologies underlying midwifery practice at the organisational level. As the result, the midwives' identity dissonance arose. Chapter Seven elaborates on the 'action/interaction strategies' which individual midwives have used to construct their professional identity in response to the identity dissonance in practice. As a consequence of the varying strategies, a '*hybrid identity*' emerged as individual midwives were navigating themselves on an identity continuum with the 'obstetric nurse' and the 'professional midwife' at each end.

Chapter Eight integrates the categories developed from the three findings chapters to present the theoretical model '*navigating the self in maternity care*' that explains how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. Corresponding with the research questions, the model is discussed with reference to relevant literature.

Chapter Nine concludes the thesis by summarising and reflecting on the research. Implications of the research findings for the midwifery practice, education and wider policy are considered. The recommendations for future research are provided at the end.

CHAPTER TWO: HISTORICAL AND POLITICAL BACKGROUND OF MIDWIFERY IN CHINA

Similarly to that in the rest of the world, midwives in China have a long history of helping women to give birth; yet according to the traditional sociological criteria of a profession (Parsons, 1939, Abbott, 1988), in China midwifery remains as a novice profession compared with other professions such as medicine (Cheung, 2011). In order to obtain a better understanding of how contemporary Chinese midwives construct their professional identity, an overview of the historical and political background of midwifery in China is necessary, as Cheung (2011: 211) reasoned,

Modern Chinese midwifery comes from the traditional one; yet it is constantly adding and changing meanings through humanistic or holistic approaches, in terms of midwives' modernisation and professional orientation.

A thoroughly historical review of the development of midwifery in China had not appeared in any written work until Cheung's (2011) study synthesised the rare historical records and materials. Her work has unfolded the history of Chinese midwifery and has linked it with the contemporary midwifery, and thus has provided abundant information and evidence for the historical and political background discussion for this thesis.

For the analytical purpose, the following text introduces the development of Chinese midwifery at three stages with reference to the changes in the title of the midwife and the underlying historical and political changes, which have taken place in midwifery.

- Traditional midwife (*jiē shēng pó*): Chinese midwifery before 1928.
- Modern midwife (*zhù chǎn shì*): Chinese midwifery from 1928-1978.

- Contemporary midwife (*obstetric nurse*): Chinese midwifery from 1978-2010.

Based on the review, the identity crisis and theoretical basis for contemporary Chinese midwifery have been analysed, which have proposed the research inquiry for this thesis.

2.1 Traditional Midwife (*jiē shēng pó*): Chinese Midwifery before 1928

In the ancient times, as with many other countries, childbirth in China was a domestic affair. Female friends, family members or traditional midwives helped women to give birth. Midwifery became a female occupation after the later 14th century, and there were many different lay terms for midwives of that time, such as *zhuò-pó* (坐婆), *kān-chǎn* (看产), *wěn-pó* (稳婆) or *chǎn-pó* (产婆) (Cheung, 2011). Until the early 20th century, these traditional midwives were commonly addressed as *jiē shēng pó* (接生婆) (Cheung, 2009, Harris et al., 2009), which in Chinese means an old woman who assists labour and birth. These traditional midwives were normally illiterate who acquired midwifery skills through the experiences of their own birth, attending births of their family or via apprenticeship (Cheung, 2009). The qualification of the traditional midwives was evaluated by their age, personal experiences in childbirth and reputation in local communities (Cheung, 2009, Harris et al., 2009). Although there was no formal training during this time, those midwives followed a ‘holistic’ philosophy of midwifery care and practised independently (Cheung, 2011). Their practices were influenced by the traditional Chinese concepts *yīn* and *yáng*, which emphasises “the balance of the mind, body, spirit and soul as a whole” (Cheung, 2011: 213). In this sense, this ‘holistic’ approach to childbirth is, to certain extent, analogous to the midwifery/social model in modern times, which situates childbirth in a social, cultural, spiritual and natural setting and demonstrates a woman-centred approach (Page, 2003, Van Teijlingen, 2005, DeVries, 2004, Downe, 2004). This theoretical

basis of Chinese midwifery practice gradually died out with a more specific focus on the biomedical system of knowledge in the modern period, emphasising the medical model. The medical model locates childbirth in a medicalised environment, treats childbirth as a potential risky event, and legitimately endows obstetricians with the leading position in the management of childbirth. It has thus resulted in the decline of modern midwives' autonomy and responsibility, and crisis with their professional identity.

Although midwifery was traditionally a female occupation, in a male-dominated Chinese society the social status of traditional midwives was low (Cheung, 2009). After the 18th Century, criticism from the medical profession began, going against midwives' illiteracy and portraying midwives' practice as dangerous to women and their babies (Harris et al., 2009, Cheung, 2011). However, due to the 'sex-segregated' Chinese culture there was no direct competition between the medical men and the traditional midwives as in the Western European countries, until Western medicine reached China in the early 1900s (Harris et al., 2009: 205). The Western style of medical training in this sense appeared to offer a way for Chinese physicians to bypass the 'sex-segregated' culture and step into the territory originally held by traditional midwives (Harris et al., 2009). In the meanwhile, the criticism of traditional midwives from the medical society prompted Western medicine to diffuse into midwifery by re-constructing the traditional midwifery approach through biomedical training (Cheung, 2011). Since then, by virtue of the biomedical knowledge, the medical profession has begun to exercise its power upon Chinese midwifery.

The momentous transformation of Chinese midwifery was marked by the release of the Midwives Rules on 9th July 1928 (Chinese Ministry of Health, 1928) and the establishment of the first national midwifery school in 1929 (Cheung, 2009). It symbolised a political and professional transformation of traditional midwifery to modern midwifery.

2.2 Modern Midwife (*zhù chǎn shì*): Chinese Midwifery between 1928-1978

A new era of Chinese midwifery commenced in 1928. Since then, the modern title *zhù chǎn shì* has been used in the healthcare system instead of *jiē shēng pó* (Harris et al., 2009). *Zhù chǎn shì* in Chinese means a practitioner who assists women with labour and birth without ‘gender or age implication’ as the title of traditional midwife (*jiē shēng pó*) previously had (Cheung, 2011: 190).

The historical development of Chinese midwifery before 1928 demonstrated its own characteristics. Its growth in modern times, however, mirrors many features of midwifery in Western countries, as it has been greatly influenced by Western medicine and technology (Cheung, 2009, Harris et al., 2009, Johnson, 2011). Since the 1900s, with the growth of Western medicine in China and its biomedical training for midwives, modern Chinese midwifery has gradually arisen as a profession, which has claimed its own area of expertise and has formed its body of knowledge (Cheung, 2011). However, the education and qualification standards for midwifery have primarily been based on the technological aspects of the biomedical model with the aim of coping with the criticism from the medical profession. Such use of biomedical model as a theoretical basis for midwifery professionalisation may serve as a survival means for the moment; yet this kind of ‘technological professionalisation’ (Cheung, 2011: 296) has potentially enabled medical monopoly within the Chinese maternity care system (Mander, 2002) and has been considered as a contributor to the deterioration of the midwifery profession in the contemporary era (Cheung, 2009).

At the beginning of the professionalising stage, modern midwives were trained through a formal educational system, which contained three levels of midwifery programme: the elementary, undergraduate and postgraduate (Harris et al., 2009, Cheung, 2011). The formal training gave Chinese midwives a relatively higher social status (Harris et al., 2009), but this short-lived prosperity ended in 1952 when a

'Soviet-modelled' education system was introduced (Cheung, 2009: 234). As a result, the undergraduate and postgraduate midwifery programmes were terminated, whilst only the elementary and secondary level education comprised of two or three-year midwifery training remained (Cheung, 2009, Cheung, 2011). During the Cultural Revolution between 1966 and 1976, midwifery education collapsed together with the whole Chinese system, and started to be rebuilt at the end of the Cultural Revolution in 1972 (Cheung, 2009, Cheung, 2011). Ever since, the midwifery education system has remained the model of a technical secondary programme with three-year midwifery training (Cheung, 2009). The change in the midwifery education has accelerated the decline in Chinese midwifery in the contemporary era alongside aspects of its public image and its social status.

The modern midwifery profession slid into recession in 1952 with the decline in its education as well as its political status. Since then, there have been no specific regulations solely for midwives, and midwifery practice is now regulated by the general rules established for medical practitioners (Cheung, 2011). The healthcare policy during modern times treated midwifery as one facet of obstetrics, which had established medical influence and power upon midwifery through its control over the midwifery education, regulation and practice (Cheung, 2009, Cheung, 2011). As midwifery practice was absorbed into the medical system and midwifery education declined at the secondary technical level, the professional autonomy of modern midwives was undermined and their professional identity became ambiguous. This situation has become particularly salient during the contemporary time when modern midwives (*zhù chǎn shì*) have categorised as obstetric nurses, whose practices have been confined in the Labour Delivery Room (LDR) (Cheung et al., 2005, Cheung, 2009).

Up to this point, the implications for the modern shift in Chinese midwifery are two-fold. On the one hand, midwifery has benefited from its formal status being endorsed by the government with the enactment of the Midwives' Rules, symbolising its professionalization. Conversely, this shift has also resulted in Chinese

midwives being transformed from traditional midwives who are central to holistic care to modern practitioners oriented towards biomedical approaches (Cheung, 2011, Johnson, 2011). The long term influence of such a transformation has in part accelerated Chinese midwifery to be greater regulated and defined under the medical system, which has set a stage for the marginalisation of midwifery in the contemporary period.

2.3 Contemporary Midwife (*obstetric nurse*): Chinese Midwifery between 1978-2010

As a modernisation campaign, China initiated a policy of reform and opening up during the 1980s. Under this initiative, modernisation of medicine became the focus of healthcare policy, representative of which in the maternity care system was the application of a US obstetric model, with the use of obstetricians and nurses instead of midwives (Cheung, 2009). Midwifery education gradually disappeared in the 1990s and midwifery profession became a subgroup of the nursing profession in the early 21st century (Cheung et al., 2005, Cheung, 2011). How the education was discontinued and to what extent midwives were replaced is unclear in the political documents. However, there are some indications that midwives during that period were offered the choice of either registering as nurses or becoming obstetricians with further training (Chinese Ministry of Health and Ministry of Politics, 1979). This phenomenon was mirrored in the study by Harris et al. (2007) in Xi'an, when they surprisingly found that one senior obstetrician of a maternity hospital at a rural county had originally graduated from midwifery programme.

The movement of modernisation in the Chinese maternity care system has resulted in a salient decline of midwifery, as reflected in its policy, education, qualification and the importation of doulas.

2.3.1 Policy

At the beginning of the contemporary era, the existing policies in relation to midwifery within China were similar to those of modern midwifery, which regulate midwives through the medical legislation, rather than with a distinct statutory body or professional body (Cheung, 2011). The most recent document about Chinese midwives' scope of practices I uncovered was released by the Chinese Ministry of Health in 1986 (Guo and Fu, 2009: 300), which stipulated,

Midwives are required to work under the supervision of their nursing managers and obstetricians. They are responsible to provide emotional care to women, to observe women's state during labour and birth, to inform obstetricians if any abnormal conditions are identified, to assist obstetricians in dystocia; they are responsible to assist birth for low-risk women, in charge of labour wards and infant nursery; they have the responsibility for clinical training to midwife trainees and students; they take charge of family planning, perinatal healthcare, education, maternity check-up, baby delivery out of hospital and postnatal follow-ups.

In the document, midwives are namely the principle professional in normal childbirth with a broader scope of practices. Despite this, included in the policy is the condition that midwives' practices are under the supervision of the obstetricians and nursing managers. The standards for midwifery practice are regulated based on the medical perspective, whilst midwifery is placed firmly under the medical control.

The situation was exacerbated at the beginning of the 21st century, when the hospitalisation of childbirth became a policy in the Chinese maternity care system (Harris et al., 2007, Government of China, 2002). As a result, the sphere of midwives' practices was relocated to hospital settings and the majority of hospital midwives were confined to labour wards in both rural and urban hospitals (Harris et al., 2009, Cheung, 2009). Midwives have lost their key role in promoting and maintaining health for mothers and their babies and in facilitating normal childbirth, but practise

a range of task oriented, routinised approaches, which mirror the medical model. The hospitalisation and medicalisation of childbirth in China will be further explicated in Section 2.4.

On 12th May 2008, the new Nurses Act was enacted (Wen, 2008). This places midwifery under the management of nursing, whilst the medical control over midwifery begins to exert its power through its control over nursing (Cheung, 2011). Consequently, midwives no longer possess a unique professional registration; they are registered as 'general nurses'. The role of the midwife is legitimately linked with nursing, in spite of the different origins and service organisations of the two professions. It is worrying that categorising midwives under the broad 'nurse' title has marginalised midwifery as a profession, has confused midwives as professionals, and subsequently impairs the provision of care for women (Cheung, 2009, Harris et al., 2009, Tan, 2010).

2.3.2 Education

Chinese midwifery education was gradually discontinued in 1993 (Cheung et al., 2005). Ever since, there has been a dearth of higher midwifery educational programmes in China. Midwifery education remains mainly at the diploma level in technical secondary school, and consists of three or four-year courses (Cheung, 2009, Harris et al., 2009). Recently, several midwifery courses have been taught in universities with a midwifery option that has been offered for those taking higher education nursing programmes (Cheung, 2011). As to their professional development, there are even fewer opportunities for continuing education programmes in midwifery (Harris et al., 2009). If it is needed, midwives have to choose certain nursing courses for further education. In comparison to the undergraduate and postgraduate education programmes in medicine and nursing, such diploma level midwifery preparation results in the social perception that midwives are of a lower professional status (Barclay, 2008, Cheung, 2009). Therefore, the current midwifery educational system has affected the public image

of contemporary midwives, which in turn could lead to the identity crisis in the profession of midwifery itself.

In terms of the curricula, midwifery courses are established on the basis of the medical model with an emphasis on physiological and pathological knowledge and less focus on theories and philosophy for midwifery practice, as reflected in the midwifery textbooks (Guo and Fu, 2009, Wang, 2011, Cheung, 2011). At the end of the training as such, contemporary midwife graduates seem to be generally prepared with “some common values, bio-medical specialisation, and the standards of the services” (Cheung, 2011: 307).

2.3.3 Qualifications

According to the political document released by the Chinese Ministry of Health of the Maternal and Child Health Department (1996) in 1996, all practitioners who undertook maternity practice were required to have a qualification certificate (Permit for Performing Technical Service on Mother and Infant Health Care). However, this certificate was not limited to midwives, but was also applicable to obstetricians and obstetric nurses. There would appear to be role overlapping amongst midwives, obstetric nurses and obstetricians, which could arouse midwives’ professional insecurities and role uncertainty.

Since midwifery in China has become a sub-branch of nursing, midwives are required at first to pass the national nursing qualification test and register as nurses at the national level. They can become qualified midwives after passing the test for the mother and infant health care service qualification held by the local Health Administrative Department (Han and Bai, 2008). At present, there are two types of qualified midwives in existence in the Chinese maternity care system: direct-entry midwives, who are admitted to and complete the formal midwifery programme; and nurse-midwives who are recruited from qualified nurses, either directly after graduating from a formal nursing programme or who have worked as nurses for

several years. The nurse-midwives are the candidates who undertake midwifery training informally through short-term on-the-job training in a maternity unit (Harris et al., 2009, Cheung et al., 2009) and become qualified midwives after passing the qualifications test (Han and Bai, 2008). Owing to the relatively lower number and level of midwifery programmes, there are an increasing number of nurse-midwives working in the Chinese midwifery service. Despite the absence of available statistics regarding the numbers of these nurse-midwives, during this study I found that a high proportion of qualified midwives were recruited through this route.

Considering the midwifery education and qualification, midwifery preparation in China is being mixed up with medical and nursing knowledge. Midwives therefore may be presently suffering from role confusion and identity crisis, and have difficulty defining themselves in the contemporary maternity care system (Cheung, 2009).

2.3.4 Importation of 'Doula' services

Another consequence of the opening-up policy and modernisation campaign with regard to Chinese midwifery was the importation of 'doula' services in 1996 (Cheung et al., 2005). The term 'doula' was borrowed from the North American countries, in particular from the US. The meaning has been transformed into the Chinese context, referring the practices of the 'privately hired doula midwives', who are providing one-to-one midwifery care with 'economic incentives' (Cheung, 2009: 235). Chinese doulas are comprised of two groups of practitioners: labour delivery room obstetric nurses and midwives, who are either employed or retired (Cheung et al., 2005). During the time of the current study, there was no formal training programme to prepare the obstetric nurses or midwives for the doula role. Normally, each hospital conducts its own way of training. Doula-midwives provide one-to-one continuous care to labouring women from the establishment of labour until two hours after childbirth, emphasising the primary care needs. If they are currently employed in the unit, they can also conduct the baby delivery during their

doula service (Cheung et al., 2005). In the majority of the maternity units, family members are unable to be with the woman during labour (Cheung et al., 2005, Harris et al., 2009). As the labour room is shared with other labouring women, family members are considered an inconvenience. As for the holistic care needs, the doula service has become popular with women and their families (Ling et al., 2004, Cheung et al., 2005).

The application of the doula programme has in part relieved the consumerist pressure for individualised care. However, the imported doula service has induced the split of the holistic midwife role into the role of a doula (continuous primary care) and an obstetric nurse (technical role). The consequence of such a division could lead to a loss of midwives' social and professional identity, as Cheung (2011: 276) reasoned,

The introduction of doulas into China causes the reduction of the midwife's role to a merely technical function, rather than the holistic one as in the UK. This 'technician' role is reminiscent of the labour/delivery room nurses or obstetric nurses so familiar in the US.

For this reason, Cheung et al. (2005) argued that Chinese midwifery had reached its lowest ebb by 1996 after the introduction of the North-American 'doula', in that the localised doula service and the use of the term 'doula' for midwives had caused palpable confusion of the role and identity of midwives in China.

2.4 Identity Crisis of the Profession - the Medical Model

As has occurred in many other countries, midwifery in China has undergone a number of highs and lows throughout its development. The characteristics of Chinese midwifery are embodied in its historical movement from traditional midwifery to the bio-medical midwifery of the early 20th century; being gradually undermined under the medical legislation and with the discontinuation of midwifery education in the 1990s; and being marginalised by the role of obstetric

nurses, obstetricians and 'doulas' in the contemporary era. Apart from the political status of Chinese midwifery in the contemporary time, the review of the historical and political background of midwifery indicates that the contemporary identity crisis for this profession appears to be largely a result of the shift in its theoretical basis from the holistic approach (midwifery model) to the medical model.

Since the 1920s, Chinese midwifery practice has been transformed from a traditional holistic approach to a modern biomedical orientation (Cheung, 2011, Johnson, 2011). Midwifery training and regulation has gradually been placed under a 'highly medicalised and state-sponsored birth model' (Johnson, 2011: 18). The modern midwives in this sense have been trained and practise primarily under the medical orientation. Particularly with the opening-up policy in the 1980s, the medical model of childbirth, borrowed from Western countries and symbolised by the belief in progress, has been readily adopted by state authorities (Cheung, 2009). Modern medical science has dominated the maternity care system, leading to the medicalisation of childbirth throughout China (Barclay, 2008).

There is a vast literature worldwide on the widespread use of the medical model in childbirth. For the purpose of this study, discussion of the medical model focuses on its impact upon the constructs of Chinese midwives' professional identity in practice. Underlying this model, there is an assumption that "all pregnancies and births are potentially pathological until proven to be normal" (Wagner, 1994: 30). The practice under the medical model is characterised by a set of obstetric monitoring and interventions aimed at actively managing childbirth by modern biomedical obstetrics (DeVries, 2001). Maternity professionals are required to monitor and manage childbirth based on the 'normal' standards that are defined by the medical authorities (DeVries, 2001, Robertson, 2002, Harris et al., 2007). Such a medical approach to childbirth has been criticised by a wider society, such as the feminists, sociologists, midwifery scholars, for undermining women and midwives' autonomy in childbirth (Oakley et al., 1996, Murphy-Lawless, 1998). In terms of its dominance over midwifery care, Wagner (1986) argued that it had redefined childbirth with

medical terms through its emphasis on the pathological aspects, and thus has assumed obstetricians' authority in the management of childbirth. In a similar vein, with the prevalent use of the medical model, midwifery in China has been placed and regulated within the medical system. The increasing dominance of the medical model in Chinese maternity care system implies,

Medical 'experts' have a growing part to play in the routine operation of maternity services, and this reinforces the 'limbo' position of Chinese midwives. As a result, Chinese maternity services could neither promote normal birth nor recognise the knowledge and expertise of midwives and their profession. (Cheung, 2011: 309)

In this regard, midwives' tacit knowledge based on holistic care is often invisible within the maternity care system. In practice, they appear to be moving between holistic views and medical perspectives of women and childbirth, being left without a unique professional identity (Cheung et al., 2009).

With the tenet of the medical model of childbirth, in 2002 the Chinese Government worked towards a total hospital delivery service, aimed at improving safety and preventing childbearing mortality for women and babies (Government of China, 2002). With regard to structural relations, the hospital has been viewed as an epitome of powerful medical influences, where medical norms predominate and legitimately regulate the role of other maternity professionals (Purkis, 2006, Harris et al., 2007). In hospital settings, Chinese midwives work under the principles and guidelines set up by the medical profession. The status and power of obstetricians over midwives appears to be well entrenched in such a workplace structure (Harris et al., 2007). Whilst the professional autonomy and responsibilities of midwives are largely constrained in hospitals they are gradually losing their holistic view of childbirth under the medical paradigm, and the identity crisis for the midwifery profession is becoming more perceptible (Cheung et al., 2009). It could be argued that the problems for Chinese midwives' professional identity construction are partly the result of the profession being assimilated into the philosophy of childbirth

that is based on the medical model rather than its holistic approach (the midwifery model).

In many countries, with the purpose of regaining midwifery jurisdiction as well as providing women with continuous care, midwives have diverted their work domain from the hospital to the community (Green, 1998, AIMS., 2002, MacDorman et al., 2010). Although the medical power is still persistent, a variety of midwife-led models outside of hospital settings have achieved palpable success for midwifery as a profession to be known (Hundley et al., 1995, Hatem et al., 2008, Hunter, 2004). In China, which is profoundly influenced by the medical discourse, hospitalisation of childbirth is a central target in maternity care policy (Government of China, 2002) and the obstetrical control over childbirth has become the norm (Barclay, 2008). In line with Murphy-Lawless' (1998) argument, it can be seen that policy discourse in the maternity care system has been an important factor in supporting the medicalisation of childbirth, justified by the claims of safety and the notion of risk.

However, although the hospitalised and routinised management of childbirth claims to aim at decreasing maternal and perinatal mortality, the outcomes of such medical interventions elsewhere have rarely validated its effectiveness (Waldenstrom and Nilsson, 1997, Hatem et al., 2008). Rather, as the result of such medicalised childbirth, there has been an abnormally increasing rate of labour augmentation, induction, instrumental deliveries and caesarean sections occurring in China. A national survey on Chinese midwifery practice in 2007 revealed that the average proportion of caesarean sections was 38.0% (Wang et al., 2007); the proportion of episiotomies per 100 vaginal deliveries was 44.9%; the percentage of births delivered by vacuum extraction was 3.6%; the percentage of forceps deliveries was 1.9%; and the use of breech extraction and internal version for vaginal delivery were 1.4% and 0.2%, respectively (Wang et al., 2007). In addition, according to data provided by the World Health Organisation (WHO) in 2008, the average rate of caesarean section in China had reached 46.2% (Chen, 2011). Although the survey results at the national level have revealed highly medicalised

childbirth in China, the reality appears to be more serious in certain local areas, particularly in the larger and more technological hospitals (Tang et al., 2006, Mander and Cheung, 2006, Harris et al., 2007, Harris et al., 2009).

With the midwifery profession suffering from an identity crisis under the medical control, midwives presently find it difficult to define their role in practice. Cheung (2011) noted that since modern midwifery is subsumed into the medical system, there has been a struggle for midwives to establish their professional boundaries with obstetrics. There are several issues, which may contribute to such role conflict, such as the struggle to gain professional recognition and retain professional status, diversity of practice; and the resultant confusion regarding the nature of midwifery care. Becoming a sub-branch of the nursing profession and the application of doula services further contributes to this role conflict (Cheung, 2009).

Midwives have expressed their desire to demonstrate the uniqueness and specific expertise of midwifery care in order to maintain role security and to retain their professional status (Cheung et al., 2009, Cheung et al., 2011). However, in order to demonstrate the uniqueness of the profession there is a need to be clear about its theoretical basis. The development of the midwifery model is emphasised for this purpose, and is expected to re-construct professional practice for the revival of natural childbirth in China (Cheung et al., 2009, Mander et al., 2010) and facilitate midwives to clarify their professional role and retain their professional identity.

2.5 Theoretical Basis for the Profession – the Midwifery Model

The open-up policy in the 1980s has accelerated modernisation and the social development of China, which has simultaneously opened a door for international communications and academic exchanges in midwifery care. The international studies which emphasise the importance of the midwifery model present a counter-discourse to the medical notions (Hatem et al., 2008, Walsh and Steen, 2007, ICM,

2011a) that are presently being held up as a means for defining and regulating Chinese midwives' professional work.

The midwifery model takes a holistic view, under which childbirth is viewed undoubtedly not as pathogenic, but a physiological process embracing body, mind, spirits, social and cultural values (Rooks, 1999, Walsh, 2007). This model is also known as a social model with an emphasis on woman-centred care and a belief in women's inherent ability to give birth (Van Teijlingen, 2005). Under such a model, midwives work with the labouring women and their families based on mutual trust and respect, and empower the women with informed choices (Hunter, 2002b, Carolan and Hodnett, 2007). Midwives are more likely to accept greater variation as long as the woman and baby are undergoing childbirth well (Schlenzka, 1999, Rooks, 1999). This model of care focuses on a woman-centred concept, aiming for a healthy mother and baby, and also for the satisfaction of individual needs (Hyde and Roche-Reid, 2004). The application of such model in practice has served as a theoretical basis for the midwifery profession worldwide to retain and maintain their professional autonomy, status and job satisfaction, particularly in obstetric dominated hospital settings (Sandall, 1995).

In China, with the support of the midwifery discourse from international communities, some progressive thinkers have been encouraged to question its currently marginalised professional status, and take action on seeking the professional recognition by re-establishing midwifery education and promoting midwifery care in practice.

One example for the re-establishment of midwifery education is the international collaboration between Peking University Third Teaching Hospital and Wintec Polytechnic University of New Zealand for Midwifery Education and Practice in 2006 (New Zealand Embassy, 2006). Considering the absence of legislation to protect the professional roles and position of midwives and the lack of academic capacity in the contemporary period of Chinese midwifery, the prospect of such an initiative has

not been viewed favourably (Cheung, 2009). Notwithstanding, such a scheme has inspired Chinese midwives to re-examine the contemporary midwifery education system and seek reform.

In practice, one of the most significant initiatives of the midwifery care model, a midwife-led normal birth unit (MNBU), was developed in Hangzhou in 2007. Aimed at retrieving the traditionally holistic approach to midwifery care, the MNBU emphasised woman centeredness and promoted normal birth (Cheung et al., 2009, Mander et al., 2010). This project highlights the feasibility of the midwifery model in the Chinese hospital context. The holistic model has enabled the establishment of a supportive relationship between the midwife, the woman and her family during childbirth, encouraging normal birth and increasing satisfaction from service users (Cheung et al., 2009, Mander et al., 2010). It has also provided a supportive environment for the midwives to enact their professional roles of supporting normal birth to their full potential. The experiences in the MNBU have also in return encouraged midwives to proclaim their profession (Cheung et al., 2009, Mander et al., 2010). As a means of demonstrating the value of the midwifery care in the system dominated by the medical model and advocating the profession, the MNBU now acts as an exemplar for midwifery services in China.

Moreover, in response to the call from the WHO to bring down the high caesarean section rate, health officials have also expressed their willingness to reconsider the role of midwives (Chen, 2011). The Chinese Maternal and Child Health Association (AMCHA) (2010) has initiated a five-year (2010-2014) demonstrative project “promoting natural childbirth, safeguarding the wellbeing of mother and baby”, which is commissioned by Chinese Ministry of Health. The project aims to create a healthy social environment and to implement a series of midwifery skills and maternal education schemes to promote natural birth. One of the project objectives is clarifying midwives’ professional title and establishing a national midwifery educational programme.

The above academic and governmental initiatives are premised on the application of the midwifery model in China. With budding support from both state and academic bodies, the newly revived midwifery discourse has begun to exert its influence on Chinese midwifery. This resurgence of interest in the midwifery model serves as a theoretical tenet for the organisation of the identity of the midwifery profession and delivery of midwifery services, although at the present time this has been mainly emphasised at the academic level.

In the meantime, medical discourse has been continuously adjusted over this period to pursue the development of modern technology and its financial incentives (Cheung, 2011). Surrounded by the existing dominant medical culture with an emphasis on risk management and cost-effectiveness, the newly revived midwifery model is facing significant challenges. The problem is, although the midwifery model seems to impart constructs valuable for re-constructing professional practice, there is no clear guidance on what the midwife's role means in the Chinese maternity system to date. The identity crisis for the profession may continue to be a problem if midwives are either not clear about the theoretical underpinnings of their professional role or unable to enact them in practice.

2.6 Summary

The preceding text has analysed the historical and political development of Chinese midwifery, which has helped to provide an understanding of the identity crisis for the midwifery profession during the contemporary era. Due to the absence of a distinct statutory body, professional body and education system, midwifery as a profession in China has gone through a marginalised period. Particularly with the dominant use of the medical model, the term 'midwife' in China currently seems to be constructed with its own meanings, and is being mixed up with the role of obstetric nurses, obstetricians and doulas (Cheung, 2011). The recent struggle and actions informed by midwifery discourse has manifested midwives' desires to clarify

their professional identity and secure their professional status by reclaiming the midwifery model as the theoretical underpinning for the profession.

From a collective perspective, the midwifery model is meant to re-construct the ideology of the professional group and guide the identity construction of individual midwives. However, owing to the dominance of the medical model in both midwifery education and regulation, this newly revived theoretical basis (midwifery model) for the midwifery profession may not manifest unanimously in the language or practice in the personal paradigms of midwives. To reach an overall understanding of the constructs of midwives' professional identity, it is necessary to explore how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system from both professional and individual perspectives.

CHAPTER THREE: LITERATURE REVIEW

3.1 Introduction

Chapter two presented the historical and political context for understanding the construction of the professional identity of hospital-based midwives in China. The theoretical context is now considered. It begins with an analysis of the literature pertaining to the theoretical perspectives underlying studies on professional identity construction. This will be followed by a critical review of the empirical studies on midwives' professional identity in both the international and Chinese context.

In accordance with the common principle for literature review in grounded theory studies, the relevant literature was reviewed in two stages. The initial review was undertaken when preparing the research with the purpose of identifying a gap in the existing research and formulating general research questions. A more comprehensive review was conducted towards the end of data collection and analysis, in order to compare the developed theoretical categories with the existing literature. Both are integrated in this chapter, which is organised by means of the frame of the theoretical model developed from this study (Charmaz, 2006).

In section 3.2, there is an explanation of the literature review procedure and search strategy under grounded theory approach, and a summary of the key empirical studies on the subjects of 'midwifery' and 'identity'. An analysis of the theoretical underpinnings for studies on professional identity construction is presented in section 3.3. This is followed in section 3.4 by an in-depth critique of the issues pertaining to professional identity construction in the existing midwifery literature, along with the analysis of the relevant empirical studies in the broader setting, including the definition of being a professional midwife, the professional status of midwifery and the ideology underlying midwifery practice. In conclusion, section 3.5 outlines the focus of the research for this thesis.

3.2 Literature Review under Grounded Theory Approach

The aims of grounded theory are to develop theory grounded in the data (Glaser and Strauss, 1967). Thus any information that may add to the researcher's preconceptions of the subject under study needs to be contemplated. For this reason, the role of the literature in grounded theory (particularly the time of commencing literature reviews), has been one of the major debates amongst grounded theory researchers, e.g. (Glaser and Strauss, 1967, Dey, 1999, Charmaz, 2006). The concern of traditional grounded theorists is that undertaking a literature review prior to data analysis has the potential to contaminate the data by the existing theory (Glaser and Strauss, 1967). They thus suggest delaying the literature review in order to prevent the researcher from imposing preconceived knowledge upon data. However, even the classic grounded theorists, Glaser and Strauss's, stance on prior knowledge is somewhat ambiguous, as noted by Charmaz (2006). For example, in *Theoretical Sensitivity*, Glaser (1978: 72) acknowledges the necessity of prior knowledge for the development of theoretical codes as follows:

It is necessary for the grounded theorist to know many theoretical codes in order to be sensitive to rendering explicitly the subtleties of the relationships in his data.

In addition, Strauss and Corbin (1990: 48) state that:

we all bring to the inquiry a considerable background in professional and disciplinary literature.

Further grounded theorists, such as (Dey, 1999, Charmaz, 2006) have adapted the views of Glaser and Strass (Glaser, 1978, Strauss and Corbin, 1990) when it comes to the literature, by arguing that we can take a critical stance towards the existing theories and 'earn their way into your narrative' (Charmaz, 2006: 166). The literature review undertaken for this study took this stance, as the PhD proposal demands a thorough knowledge of the studies and theories in the field before conducting the research. Instead of commencing literature review after completing

the data analysis, this study has reviewed the extant theories and studies in two stages.

3.2.1 First Stage Literature Review

The initial review was conducted when preparing the research proposal for the first year examination board. Its aim was to identify research gaps in the subject being studied, defining general research questions and choosing a suitable methodology for exploration. During this stage, I reviewed the theoretical perspectives underpinning existing studies on professional identity construction, followed by a critical analysis of the relevant available research on professional identity in the midwifery literature. The literature reviewed during this stage remained in the background until the theoretical categories were developed from the data, as suggested by Charmaz (2006).

3.2.1.1 Literature Sources

The sources for the literature review were identified through electronic databases, including CINAHL, MEDLINE, COCHRANE LIBRARY and SEARCHER of the University of Edinburgh. Google Scholar and digital theses were also used to identify the relevant articles and studies. The related policy documents and reports were obtained through the government department's websites and professional midwifery websites, such as 'Chinese Ministry of Health', 'The International Confederation of Midwives' and 'The Royal College of Midwives'. These documents provide the guidelines and context for midwives' professional identity construction both in China and in the international context (the documents and reports in relation to Chinese midwifery were presented in Chapter Two, while the materials related to midwifery in the international context are discussed in this chapter). References from the accessed papers were then followed up to identify additional literature.

3.2.1.2 Topic and Search Terms

With regard to the aim of the research, two broad subject areas were searched in the literature: professional identity and midwifery. The keywords and terms pertaining to the two subject areas were used: 'professional identity'; 'professional identity construction'; the combination of 'midwifery/midwife/midwives' and 'identity'; 'midwifery/midwife/midwives' and 'professional/occupational identity'; 'midwifery/midwife/midwives' and 'professional self/professional selves'.

3.2.1.3 Search Criteria

Although research on professional identity construction can be traced back to the 1950s (Costello, 2005), studies specifically addressing the issue of professional identity in midwifery have only been available since the 1990s (Langton, 1991). Therefore, the timeframe for the literature search for this study was from 1990 to the present, while the limitation not placed on the review of theoretical perspectives of studies on professional identity construction. The inclusion criteria applied to the literature review are listed below:

- Journal articles with full text;
- Policy documents and reports commissioned by health service departments or professional organisations;
- Published in English;
- Policy documents and reports of Chinese midwifery published in Chinese;
- Relevant and accessible digital theses.

3.2.2 Second Stage Literature Review

The second stage literature review was conducted towards the end of the study, in order to locate the research findings within the related literature. In the later stages of the study, I returned to the existing literature in order to make comparison with

the theoretical categories developed from this study. The review of the literature was essentially an iterative process integrating literature (as identified through the formal review) and engagement in discussion with the wider research of relevant papers and reports. It is this merging of literature which is presented in the literature review and subsequent discussions of the research findings.

3.2.3 Summary of the Key Empirical Studies on the Subjects of ‘Midwifery’ and ‘Professional Identity’

Because of the marginalised professional status of midwifery in relation to the medical profession and the medical dominance in midwifery practice, there has been a constant debate of this profession in terms of how to define itself (Annandale and Clark, 1996), and what constitutes practitioners’ professional identity (Lane, 2002, Hunter, 2004, Davis-Floyd, 2007). However, in comparison to the variety of research on identities in other professional disciplines, only a small number of studies in midwifery literature have explicitly engaged in this subject.

Previous studies in the 1990s that focused on American nurse-midwives’ occupational identities have provided some insights. Based on the reliance of nurse-midwifery practice on the medical model, Langton (1991) classifies the nurse-midwives into three types: the dependent midwife, interdependent midwife and independent midwife. In the light of the different degree of the nurse-midwives’ medical reliance, Langton (1991) assigns them with three types of occupational identities: nurse, nurse midwife, and midwife. In the later Scoggin’s (1996: 38) study, the findings indicate that American nurse-midwives professionally drew on their traditional midwifery ideology (‘advocacy, normalcy, competency, authority and autonomy’) to position themselves in midwifery, rather than identifying with physicians or nurses.

In the more recent studies on this topic in the international context, some contextual issues that perplex the construction of professional identity in midwives were identified, including: (1) the marginalised professional status caused by

political and market forces (Rosenfeld and Foley, 2007); (2) the ideological influences of the medical model in midwifery practice (Lane, 2002, Purkis, 2006); and (3) the work (work setting) related professional identity (Hunter, 2004). Several studies have further examined how midwives engaged in their professional identity construction in response to these contextual issues from different perspectives, such as: (1) emotional work (Hunter, 2004, 2005); (2) boundary negotiation and impression management (Foley, 2005); (3) discursive use of medical discourse in practice (Foley and Faircloth, 2003); and (4) legitimate peripheral participation (Purkis, 2006). The discussion and analysis of these studies are detailed in section 3.4. To facilitate understanding, a summary of these key empirical studies is presented in Appendix A.

3.3 Theoretical Underpinnings for Studies on Professional Identity Construction

Professional identity is a focal point for many researchers who are interested in professional studies, as one of the distinctive characteristics of a profession is associated to the professional identity developed by its members (Costello, 2005). The construction of professional identity has been explored in the literature across various disciplines and from different perspectives e.g. (Brott and Myers, 1999, Gee, 2000, Beijgaard et al., 2004, Johnson et al., 2012). There are multiple characteristics and dimensions pertaining to the study on this subject, depending on the way the researcher looks at it. An overall review of all literature in terms of professional identity is therefore beyond the scope of this study. The personal reflections and background review of Chinese midwifery development in Chapter Two have shed light on the research focus for this thesis. As the profession is currently experiencing identity crisis, the subject of this study comprises (1) the identity constructs that hospital-based midwives use to define their professional identity and (2) the manner in which individual professional identity is constructed in the contemporary Chinese maternity care system. This section thus reviews the key theoretical underpinnings for studies on professional identity construction (particularly on

‘identity work’ that is usually triggered when identity crisis happens) with the purpose of increasing my theoretical sensitivity to the data collected for this study.

3.3.1 Structural Functionalist Perspective

Since the 1950s, research into professional identity has been seen through the eyes of structural functionalism (Costello, 2005), through which professional identity is viewed as uniformity, being formulated within institutionalised systems (Jenkins, 2008). This perspective has maintained its influence upon the existing studies, particularly in Institutional Theory (Chreim et al., 2007) and Social Identity Theory (Tajfel and Turner, 1979, Hogg et al., 1995). The relevant research is based on the proposition that social action is primarily determined by social structures. It tends to locate identity at the macro level, emphasising the impact of institutional environments upon the changing professional organisations and professional boundaries (Chreim et al., 2007), whilst the individual is viewed as an institutional being (Corlett, 2009, Burrellier, 2008). This view assumes a ‘strong identification inducement process’ at the institutional level, that shapes the identities of the members involved (Chreim et al., 2007: 1517). By assuming that the social structure (‘objective roles’) determines ‘subjective identity’, the structural functionalist appears to treat both the ‘professional role and professional identity as identical’ (Costello, 2005: 30). As a theoretical framework, structural functionalism focuses professional identity studies on the perspective of formal identification, thus it is not suitable to account for the diversity, conflict, and (at the most basic level) the role of the human agency (Costello, 2005).

Therefore, despite the fact that professional identity studies from a structural functionalist perspective have contributed to the existing knowledge of the institutional mechanisms that regulate the identities of its members (Chreim et al., 2007), further theoretical perspectives are required if the individual dynamics at the micro level are to be taken into account. These theoretical perspectives need a focus on the meanings, actions and interactions of individual professionals within organisational settings (Townley, 2002, Chreim et al., 2007).

3.3.2 Symbolic Interactionist Perspective

From the 1960s, Symbolic Interactionism has emerged and gradually taken the dominant position of structural functionalism in studies on professional identity construction (Costello, 2005). Symbolic Interactionism is based on three premises, as follows:

“human beings act towards the things on the basis of the meaning that the things have for them; the meaning of things is derived from, or arises out of, the social interaction that one has with one’s fellows; these meanings are handled in, and modified through, an interpretative process by the person in dealing with things he encounters” (Blumer, 1969: 2).

From the Symbolic Interactionist point of view, human beings do not passively respond to the social structure, but participate in an interpretative process in order to generate, adjust and change the meanings of their daily social interactions. Studies from the Symbolic Interactionist perspective engage with identity in the micro contexts, exploring the ways in which individuals construct their identities through interactions with a sense of self (Corlett, 2009). The three principle elements of Symbolic Interactionism are embodied in the studies of professional identity construction (McElhinney, 2008) in terms of:

- Individuals’ self-formation (e.g. self-validation) (Burke, 1991, Stets and Burke, 2003)
- The significance of the interaction with others and the meanings derived from such interactions (e.g., community of practice and identity formation) (Wenger, 1998);
- The influence of the context in which these interactions occur and meanings emerge (e.g., the organisational control upon identity) (Alvesson and Willmott, 2002).

From this point of view, professional identity is constructed through a process of self-formation in which social interaction and self-reflection are basic processes,

whereby meanings emerge as a consequence of individuals' interactions within the social world and rely on their reflective interpretations of these interactions (Hogg et al., 1995). Social structures and individuals' interactions with them are both central to the interpretive process of professional identity, in which the individual is an active interpreter. This theoretical perspective into identity is particularly evident in Identity Theory (Stryker and Burke, 2000) and emphasises types of 'identity work', which highlight the subjective experiences (perceptions and interpretations) and related actions undertaken by professionals in order to craft their identity. As a central concept to this thesis, the theoretical assumptions and key empirical studies of identity work are analysed in the following section (3.3.4).

Therefore, while structural functionalists perceive professional identity as uniformity, symbolic interactionists identify multiple identities. Structural functionalists see "the professional roles and professional identity as objective and subjective expressions of the same system", symbolic interactionists view "a spectrum of positions between external role and internal core, and the contents of those positions can vary greatly" (Costello, 2005: 31). In light of this, professional identity studies from the symbolic interactionist perspective have contributed to the understanding of micro dynamics in the process of identification, by attending to the actions and interactions, interpretations and meanings of the agents in the organisational context. These have made advances from the structural functionalist approach. However, within the context of Chinese midwifery, the overall understanding of the midwives' professional identity construction requires an examination of the wider institutional environment, as institutional forces (such as the government policies) have the ability to restrain or empower the identity construction (Chreim et al., 2007).

3.3.3 Identity Politics Perspective

The ascendance of identity politics in 1980s has increased academic interest in studies of professional identity. The identity studies from the perspective of identity politics involve the use of power and political activity (Payne, 2006, Castells, 2004).

This associates the declaration of a distinct and positive identity with empowerment of individuals as well as the social group (Costello, 2005).

The origin of identity politics stems from the concern that one's personal or group identity is constructed within a social structure where the identity is defined by the dominant others. Classically, the issues are related to the characteristics of personal identity, such as gender, race, class and nationality, e.g. (Crenshaw, 1991). The most explicit example is reflected in feminist studies that view the identity of women as defined within a dominant male culture. Similarly, midwifery has frequently claimed that its identity is moulded by the institutional culture dominated by medicine. Such establishment of identity was defined by Castells (2004: 8) as 'legitimising identity'; through which the institution attempts to rationalise the role allocated to the professions and the power relations between them.

Castells (2004) also contends that any social construction concerning identity will take place within the context of power relationships. Where individuals are devalued or stigmatised by the dominant groups, resistance to this control and dominance can be evoked. This is identified by Castells (2004: 8) as 'resistance identity'. This may be reflected in current Chinese midwifery through the profession claiming to legitimise and officialise its distinctive identity, with the aim of establishing independence from the definition determined by the medical profession.

However, resistance identity has been viewed as merely a form of reactive response to the category dictated by the dominant social structure, while the internal interpretations of the subordinate group are still confined by the external definition (Payne, 2006). The more effective approach is to enact resistance identity in order to change the social structure. This is what Castells (2004: 8) terms as 'project identity': when individuals deliberately employ available cultural and social resources in order to construct a new identity, seeking 'the transformation of overall social structure'. In relation to the contemporary development of midwifery in China, such transformation may be seen in the initiatives the profession is

undertaking in an attempt to re-establish its training, and restructure midwifery practice, based on the midwifery model.

In the writings on professional identity inspired by identity politics theory, professional identity is viewed as:

“something that must be ‘claimed’ in a political/personal ‘struggle’ against stereotypes, as individuals and groups seek to ‘construct’ a ‘usable’ form of professional identity” (Costello, 2005: 32).

The historical and political discussion concerning Chinese midwifery in Chapter Two reviewed the identity crisis for the profession in the contemporary era. While attempting to understand the means by which hospital-based Chinese midwives describe their struggle to retain a unique professional identity, the literature on identity politics offers valuable insights, as discussed in the Findings Chapters.

3.3.4 Identity Work

‘Identity work’ is a key concept pertaining to the core category developed from this study in order to explain how hospital-based Chinese midwives construct their professional identity within the contemporary maternity care system. Previous studies suggest that identity work is likely to be triggered by specific events or experiences, such as an identity crisis (Costello, 2005) or role/career transition (Ibarra, 1999, Ibarra, 2007). The concept of ‘identity work’ and the theoretical underpinning of the empirical studies pertinent to identity work are reviewed in this section.

The term ‘identity work’ has appeared occasionally in the broader literature in social science (Watson, 2008), and is used to describe the act of the ‘agency’ in the process of identity formation. In organisational studies, this concept has been formally referred to as a continuous process of ‘identity creation, regulation, negotiation and modification’ (Adams and Crafford, 2012: 2), which emphasises the individuals’ engagement in: “forming, repairing, maintaining, strengthening or

revising the constructions that are productive of a sense of coherence and distinctiveness” (Sveningsson and Alvesson, 2003: 1165). Although the analysis of this concept, and the succeeding empirical studies on this subject, have been aware of the influences social context can exert upon identity work, it has been argued that the definition of identity work focus primarily on the internal aspect of identity (Watson, 2008). For this reason, by drawing on Jenkins’ (2008) dialectic interaction between the internal and the external aspect of the self, Watson (2008: 129) reconceptualises this concept by carefully balancing and settling the tensions between the self and the external categories denoted by the social context:

Identity work involves the mutually constitutive processes whereby people strive to shape a relatively coherent and distinctive notion of personal self-identity and struggle to come to term with and, within limits, to influence the various social-identities which pertain to them in the various milieux in which they live their lives. (Watson, 2008: 129)

This ‘mutually constitutive’ understanding of identity work is one shared by this thesis, as this study is interested in individuals’ micro-level dynamics in their professional identity construction, and also aims to explore the structural forces underlying identity.

Along with its conceptual development, there have evolved within its empirical studies a number of theoretical perspectives in terms of identity work. One area of identity work research is underpinned by Symbolic Interactionism, focusing on the process of identity work and development of the model accounting for its tactics. For example, Ibarra’s (1999) work concerning banking professionals’ adaption to a career change, identified that these professionals engaged in a negotiation process, wherein their experimentations with their ‘provisional selves’ served as a trial for possible professional identities. In a study of a group of health visitors in the UK who were faced with a changing practice context, Machin et al., (2012) develop a role identity equilibrium model in order to explain the interactive identity work occurring at different levels of these health visitors’ practice. This is comprised of

three principle categories: (1) professional role in action; (2) interprofessional working; (3) local micro-systems for practice.

A further approach is underpinned by identity politics. For example, Costello (2005) has summarised four forms of identity work used to reconcile the conflicts between professional identity and some aspects of personal identity (such as gender, race and class). The first is to create a new professional role. One example, according to Costello (2005), is reflected in Drachman's (1990: 2414) study of early women lawyers, who 'nurture' their new professional role within clubs established by themselves, whereby they endeavour to maintain the equilibrium between the internal feminine concept of being 'modest, sentimental, and caring' and the external expectation of the profession being 'assertive, rational and objective'. Creating a new professional role is akin to Castells's (2004) 'project identity', yet it is difficult to achieve within short time and cannot resolve individual professionals' immediate conflict (Costello, 2005). The second solution is in a similar vein to Castells's (2004) 'resistance identity', which involves consciously resisting the identity dictated by dominant cultural values. The third solution is the refusal to make a choice, but settling to 'realign' the conflict identities (Costello, 2005: 33). In addition to these three types of identity work, Costello (2005) also identifies the fourth solution to identity conflict: adopting an identity in the dominant social structure, while replacing the one that is in conflict with the dominant identity. Due to its negative effects, such form of identity work has been downplayed by researchers who are influenced by identity politics.

More recently, researchers have indicated that 'neither the structural nor the agentic model' of identity work are 'wholly sufficient' to understand the complex and dynamic nature of identity (Oliver, 2007: 38). They require a direction towards 'discursive conceptualisation of identity' that lays an emphasis on the role of 'multiple and competing discourses' in identity construction (Oliver, 2007: 38, Watson, 2008). This leads to a further contemporary trend of identity work studies, drawing on narrative and discursive perspectives, which have interested midwifery

researchers (Foley and Faircloth, 2003, Pollard, 2011, Foley, 2005). One example in midwifery literature is Foley's (2005) study on midwives' identity work in the United States. These midwives were seen to be positioned at the margins of the mainstream medical system, thus holding competing identity categories that required them to negotiate. On examination of the midwives' individual, collective and public identity work, Foley (2005) focuses attention on their narrative practices. These midwives were found to use boundary negotiation and impression management in order to frame their public identity in relation to the representations of the midwife in the history and media discourses. In some situations, individuals also employed counter-discourse to legitimate their professional identity, as identified in Foley and Faircloth's (2003) study, in which the participants drew on the discourse of medicine in order to validate their profession (this study is further analysed in Section 3.4.4). This approach to identity work studies can be viewed as a narrative or discursive exercise, where identity work strategies are manifest in the form of stories or discourses that individuals present themselves by drawing on the discursive resources at their own disposal. This form of working on one's professional identity departs from the more traditional classification of identity work as outlined in previous studies.

For this thesis, the above theoretical perspectives underlying identity work studies (including the identity work based on identity politics, individual identity negotiations strategies and discursive practices for identity construction) are not exclusive, but mutually integrated in order to interpret the subject under discussion. The details are presented in the finding chapters (Five-Seven).

3.3.5 Summary of the Theoretical Underpinnings

The preceding analysis of the theoretical underpinnings of studies on professional identity construction has enhanced my theoretical sensitivity to the data and facilitated the comparison of the categories developed from this study with existing knowledge. The comparison between the developed categories and existing theories in the second stage of the literature review has, in turn, enabled me to

reinterpret the literature and identify pertinent elements from the existing knowledge in order to discuss the developed theoretical model. None of the theoretical perspectives discussed previously can, in themselves, sufficiently account for the ways in which hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. The theoretical model developed from the study integrates these theoretical perspectives by interpreting the construction of midwives' professional identity across three analytical levels: institutional, organisational and individual. Different forms of professional identity work (and the contextual factors lying behind it) are analysed and discussed in finding chapters (Five-Seven).

3.4 Research Context: Professional Identity Construction in Midwifery

After reviewing the theoretical underpinnings for this thesis, this section turns to the relevant literature in midwifery in order to examine the contextual factors that influence midwives' professional identity construction in both the international and Chinese context. The following text gives an in-depth critique of the issues pertaining to midwives' professional identity construction. Included in this section are examinations of: (1) the definitions of a professional; (2) defining characteristics of being a professional midwife; (3) the professional status of midwifery; and (4) the ideology underlying midwifery practice. Along with the analysis of these contextual issues, the empirical studies related to the construction of midwives' professional identity are critically reviewed. A summary of the key empirical studies on 'midwifery' and 'professional identity' is presented in Appendix A.

3.4.1 Defining a Professional

In the sociological analysis of professionalism, strong professional identity has (for both ethical and practical reasons) been generally considered as its foundation (Evetts, 2007). Taking professional ethics into consideration, the identity that internalises professional ethics and norms serves as a principle for practitioners to

regulate their practice effectively in the interests of the public (Freidson, 1994). It is equally important that a strong professional identity can enable professionals to act with “the authority, confidence and professional demeanour in order to convince others of their competence” (Costello, 2005: 29). However, when it comes to an exact definition of what makes a professional, there are substantial interpretations in the literature. In light of this, this section begins with a discussion of the view of what it means to be a professional that underlies the interpretations of midwives’ professional identity for the purpose of this study.

According to the traditional sociological criteria of a profession (Parsons, 1939, Abbott, 1988), professionals (e.g. lawyers, medical doctors and scientists) are regarded as higher professionals, while others (e.g. teachers, nurses and midwives) are categorised as ‘semi-professionals’. The semi-professional status for midwifery is often attributed to the power and knowledge imbalance with, and jurisdictions subordinate to, the well-established and prestigious profession of medicine (Mander, 2002). The intricate relationship between medicine and midwifery is detailed later in Section 3.4.3 and 3.4.4.

With the social changes in the postmodern era, the focus of the concept and mechanism of professionalism has shifted from the formal classification to individuals’ subjective interpretations (Freidson, 2001, Evetts, 2007). For example, in the study of paralegal workers Lively (2001) makes a distinction between the sociological interpretations of the profession in the wider society and the subjective meanings of being a professional constructed by the paralegals themselves. In the paralegals’ subjective interpretations, being a professional in their field requires the competence in and capacity of “maintaining the proper demeanour of someone in the legal field, which includes their thoughts, behaviours, appearances, emotions” (Lively, 2001 p.343). While the study is conducted in the field of law, the attention towards individual interpretations of what it means to be a professional (and how to behave as such) have implications for later studies on professionalism and professional identity.

In Chapter Two there was a discussion of the fact that (in comparison with other professionals in China), there is no dedicated education system, statutory body, professional associations or theoretical basis for Chinese midwives. The healthcare authorities regulate midwifery practice through medical legislation that has resulted in the medical dominance of midwifery and led to its current marginalisation (Cheung et al., 2005, Cheung, 2009). Recent studies suggest that midwifery in China has not managed to become an independent profession (Harris et al., 2009) and professional autonomy, (noted by Freidson (1994) as a hallmark of a profession), has not survived in Chinese midwifery (Cheung, 2011). Although the discussion in Section 2.4.5 indicates that Chinese midwives have made professional endeavours in recent years (mainly by focusing on improving midwifery practice), it also alludes to the fact that more needs to be done to reconstruct the profession and the midwives' professional identity in the current institutional and organisational context. Under such circumstances, the interpretation of being 'a professional', from the subjective perspective of the individual, offers a resource to contemporary Chinese midwives (among others) to construct, claim and maintain their professional sense of the self at the individual level. The view of this thesis is that the meanings of being a professional midwife are constructed by midwives themselves, in a process of negotiation with the social context.

3.4.2 Defining Characteristics of Being a Professional Midwife

The definition of 'midwife' in Old English highlights the essence of being a midwife. The etymology of midwife is Middle English 'mid = with' and Old English 'wife = woman'. From this literal meaning, midwives have, since their origin, been endowed with the essence of being 'with woman'. In terms of what are required to be a professional midwife, an authoritative definition is provided by the International Confederation of Midwives (ICM, 2011a). This definition has also been adopted by the World Health Organisation (WHO) and the International Federation of Gynaecology and Obstetrics (IFGO):

A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery. (ICM, 2011a: 1)

The ICM definition stipulates official criteria for the qualification of being a professional midwife. This international definition also articulates the scope of midwifery practice that covers the entire period of childbearing, including detailed responsibilities and accountabilities for these professionals and their broader work settings (hospitals, communities and home). This document offers a blueprint for midwives internationally to retain, maintain and sustain their professional status and fulfil their professional roles. However, as a general definition of the midwife, it cannot cover all midwives, as they are working in diverse maternity care systems worldwide, such as the contemporary Chinese midwives with a blurred title.

Building on this formal definition, Walsh and Steen (2007) have proposed four commonly recognised defining characteristics to theoretically underpin what it means to be a professional midwife: (1) Autonomy; (2) Normality; (3) Holism; (4) Woman-centeredness. These defining characteristics are derived from: (1) the ICM definition; (2) midwives' years of practice; (3) personal reflections; and (4) the relevant literature. Nevertheless, it is frequently the case that the achievements of these professional characteristics are constrained by the wider social structure. Thus midwives are constantly prevented from identifying with the profession. The issues that affect midwives' identification with these defining characteristics are raised in the following text and will be further addressed in sections 3.4.3 and 3.4.4.

3.4.2.1 Autonomy

As a traditional symbol of a profession, autonomy endows professionals with authority and control within their professional jurisdictions, along with the

responsibility and accountability for their practice (Walsh and Steen, 2007). Midwives are the professionals who are trained to practise autonomously, not denying collaborations with other health professionals, but with the freedom to practise, make decisions and take actions on their own, thus taking responsibility for childbearing women and their families (ICM, 2011a). Nevertheless, complete professional autonomy has barely been achieved, due to various underlying reasons. The main reason that has been commonly raised is the medical power and knowledge control over midwifery services (Mander, 2002, Brodie, 2007). As the evidence-based practices can provide midwives with necessary leverage when they encounter the medical agents and their interventions, midwives are encouraged to engage with research and base their practice on the best available evidence in order to gain their professional autonomy and take accountability for their professional actions (Mander and Reid, 2002).

3.4.2.2 Normality

‘Normality’ or ‘normal birth’ is a central concept in midwifery practice (Gould, 2000) and has an essential meaning to midwifery profession, albeit a problematic one (Downe, 2004, Downe, 2006, Page, 2010). According to the ICM (2011a) definition of a midwife, normal birth is allocated as one of the key areas of midwifery expertise. In particular, legislation in many countries explicitly link the professional autonomy of midwifery with the ‘normal birth’, e.g. the United Kingdom Central Council (Visitors., 1998). However, in contemporary society, with the development of medical technology and the increasing application of medical intervention into maternity care, the margin between ‘normality’ and ‘abnormality’ has become increasingly blurred.

Three authoritative definitions have classified ‘normal birth’ from a single clinical and physiological dimension, to the recognition of dynamic interactivity, to the holistic view of childbirth (World Health Organization, 1997, RCM, 1997, Cassidy, 1999). Nonetheless, in reality, the meaning and defining parameters of ‘normal birth’ varies when it is interpreted by different parties, (e.g. obstetricians; midwives;

childbearing women; healthcare officials) and in relation to differing geography and cultures (Downe, 2006, Mander, 2002).

3.4.2.3 Holism

Holism requires the midwife to be actively involved in the childbearing women's holistic experiences throughout pregnancy, labour and birth (Walsh and Steen, 2007). There are various interpretations of the meaning of 'holism'. The primary models of holistic midwifery care include continuity of care (this refers to the shared philosophy of practice within the midwifery care system and consistent policies) and the continuity of the carer (this refers to one-to-one midwifery care or consistent team midwifery) (Hundley et al., 1995, Page, 2003). Although the definition and scope of the holistic care model vary within different settings, its contribution has demonstrated women's positive experience and the reduction of medical intervention (Chunyi et al., 2011, Hodnett et al., 2013)

For the midwives themselves, providing holistic care to women can also increase their confidence, sense of achievement, autonomy and job satisfaction (Page, 2003, Thomas, 2006, Chunyi et al., 2011). However, studies also indicate that the actual practice environment is filled up with the heavy workload, limited time and insufficient staffing. As a result, the stress, frustration and sense of burnout are often expressed by midwives in pursuit of giving holistic care (Sandall, 1997). One of the main identifiable causes of emotional distresses is the failure to develop reciprocal and meaningful relationships with their clients (Sandall, 1997, Chunyi et al., 2011). There has therefore been a call for shared governance for midwives that can meet the requirements of both organisations and professions, in order to provide women with holistic care and protect midwives against burnout (Chunyi et al., 2011).

3.4.2.4 Woman- Centeredness

The position statement of the Royal College of Midwives (RCM, 2001) emphasises 'woman-centred care' as a philosophy of midwifery that prioritises the needs of

women and highlights the notion of empowerment to women. Evidence has revealed that the effectiveness of holism in midwifery care relies heavily on the philosophy of woman-centeredness (Green et al., 2000). It is the continuous care and empowering of women that embody the value of midwifery and permit midwives to gain recognition from their clients (Carolan and Hodnett, 2007, Fleming, 1998, Hunter, 2002). The relationship between women and midwives is central to 'woman-centred care', which is primarily focused on the aspects of 'with woman' and 'partnership' in the midwifery literature (Carolan and Hodnett, 2007). The experience and evidence concerning the practice of midwifery have demonstrated that woman-centeredness is considerably difficult to achieve. On the one hand, less evidence-based information concerning care models and limited availability of these services have affected women's decision making, especially those less educated and less resourced (Carolan and Hodnett, 2007). On the other hand, the 'partnership' between women and midwives can be challenged, in that the values central to midwifery care may not always be the same as that which women expect (Fleming, 1998).

The previous discussion indicates that these defining characteristics of a professional midwife do not exist exclusively, but are interdependent. They are closely interconnected representing the philosophy underlying the midwifery profession and the professional identity of the midwife. These meaningful aspects of being a midwife have been termed as 'real midwifery' (O'Connell and Downe, 2009). Midwives who are able to enact 'real midwifery' feel confirmed as 'real midwives' (Beake et al., 2001) and enabled to make a difference to women and gain self-fulfilment (Thomas, 2006). However, as indicated in the preceding discussion, the fulfilments of these defining characteristics are mostly restrained and repressed in the existing institutional and working context. Midwifery literature has indicated several significant challenges to midwives' professional identity construction worldwide, as follows:

- The legislations and regulations at the governmental level. Studies have established that a number of regulatory bodies do not guarantee midwifery representatives a place, and the regulation of midwifery are undertaken by authorities whose priority is focussed on medicine or nursing (Gamble and Vernon, 2007);
- The medical and technological domination. This is manifested in the hierarchy and ideology within midwives' working organisations, including its subsequent influence upon midwives' judgements and actions in practice (Donnison, 1988, DeVries, 2001, Kirkham, 1999);
- The intrinsic connection with nursing. Although, historically, the development of midwifery accompanied with nursing varied in different countries, the intimate link with nursing appears to have had a powerful role in influencing the role of midwives within the maternity care system (Mander, 2002, Dawley, 2002);
- The relationship with women. In many countries, it is still a struggle for midwives to win support and recognition from their clients, many of whom are under the misperception that only obstetricians attend births and midwives are 'obstetric nurses' (Gamble and Vernon, 2007, Brodie, 2007).

The most universal and radical influences to the sense of 'being' a midwife underlying all of these challenges are evident in the medicalisation and institutionalisation of childbirth, and the resultant loss of the professional control of midwifery (DeVries, 1993, Van Teijlingen, 2005, Hall, 2012). More specifically, it is the 'medical dominance' in maternity care system that is seen as the main force obscuring the meanings and understandings of being a midwife, both within and outside of the profession. The medical impacts upon midwives' professional identity construction are discussed in detail in the following two sections, in relation to the status of midwifery and the ideology underlying midwifery practice.

3.4.3 Midwifery Status and Professional Identity

Throughout the literature, midwifery has been viewed globally as situated at the boundary of mainstream healthcare system, which is dominated by the well-established medical profession, e.g. (DeVries, 2001, Mander and Fleming, 2002, Cheung, 2011). Accompanied by growing medical technology, medical power and control has exerted its ever-increasing institutional and ideological influence upon modern midwifery. It has been argued that, when a prestigious and powerful group exerts control and exploitation over another, less powerful group, there is an existence of oppression (Dong and Temple, 2011). By means of its political and ideological power, the dominant group can impose its own norms upon the subordinate group. The status and value of the subordinate group will then be degraded as a result (Freire and Ramos, 2009). In this sense, the relationship between the professions of midwifery and medicine is often bounded with the culture of oppression (Purkis, 2006), which inevitably affects the professional identity construction of midwives. As discussed in Chapter Two, this is the position of midwifery in China.

Young (1988: 64) has listed five indicators of inter-group oppression: 'Exploitation, Marginalisation, Powerlessness, Cultural Imperialism, Violence'. She asserts that "the presence of any of these five conditions is sufficient for calling a group oppressed" (Young, 1988: 64). When it comes to the midwifery profession worldwide, it could be argued that each of these representations of oppression exist in the relationship between midwifery and medicine (Purkis, 2006). For the purpose of this thesis, the greatest concern involves medical oppression in the jurisdictional exclusion of midwifery (Marginalisation), as discussed in Chapter Five, and its concomitant ideological power in midwifery practice (Cultural Imperialism), as discussed in Chapter Six.

'Marginalisation' refers to the institutional status, the resource and opportunity restrictions of the subordinate group by the dominant group (Young, 1988). It denotes the power imbalance in inter-group relations, which can be reflected in the

division of labour: i.e. the ways in which one group's work boundary is defined in relation to that of the other (Young, 1988). The marginalisation of one profession occurs via a process of social closure, where the dominant group has power and control over social conditions that protect its interests from other groups (Goodman, 2007). There has been a long history of the marginalisation of midwifery in relation to the medical profession in many countries, manifesting itself in restrictions of institutional status, resources and opportunities. This marginalised professional status is still experienced in countries such as the United States, Australia and China, and has been attributed to both the state and market forces (Goodman, 2007, Brodie, 2007, Cheung, 2011).

As discussed in Section 2.4.4, the rationale of the medical model is justified by the medical creation of 'risk-based discourse', which, as Goodman (2007: 619) pointed, serves as "an important tool for physicians and institutions to promote their sovereignty". Foucault (2003) uses 'medical gaze' as a metaphor to describe the discursive practices of medicine, which manifests itself in the maternity care system in its institutionalised way of depicting women's childbirth as "potentially pathological until proved to be normal" (Wagner, 1994: 30). By positioning pregnant and birthing women within the notion of risk, obstetricians have rationalised their 'expert' status. In this sense, the discursive practices of medicine can be seen as a typical means of marginalisation, whereby the medical profession institutionalises the legitimacy of its dominance over the midwifery profession in the maternity care system (Goodman, 2007).

As a consequence, the professional status of midwifery and the unique professional identity of the midwives are inevitably challenged. The identity crisis indicated in the context of Chinese midwifery (see Section 2.1.4) is (albeit in varying degrees) reflected in the broader context. Examples of this can be seen: (1) in the current professional 'insecurity' identified by Larsson et al., (2009: 377) when comparing Swedish midwives' professional experiences during the past twenty to twenty-five years; (2) the professional 'invisibility' and 'subsumed position within nursing'

identified in Brodie's (2007: 11) national investigation of the existing barriers to the role and practice of Australian midwives; and (3) the 'competing categories of identity' of midwives in the United States (Foley, 2005: 183).

Foucault (1990: 95) states that: "wherever there is power, there is resistance". A number of studies in midwifery, particularly those concerning American midwives (including direct-entry midwives and nurse-midwives), have explored the ways in which they interpret their professional identity and the practices they conduct to maintain their perceived identity. For example, in order to understand how American nurse-midwives define themselves in relation to midwifery, medicine and nursing, Scoggin (1996) carried out a two-phase mixed methods study. During the first phase, twenty nurse-midwives from different regions of the United States, and across different work settings, were interviewed. These nurse-midwives used the traditional midwifery ideological constructs of 'advocacy, normalcy, competency, authority and autonomy' to distinguish themselves from physicians and nurses (Scoggin, 1996: 38). In a similar manner to the defining characteristics discussed in section 3.4.2, these professional constructs serve as a theoretical basis for these nurse-midwives to organise their professional identity and differentiate them from its original identification with nursing (Scoggin, 1996). In most cases, however, these constructs are primarily developed at the academic level and may reflect the collective ideology of the profession, rather than their actual enactment in practice.

A recent study of interviewing twenty-six midwives in the state of Florida, Foley (2005: 183) found that, in practice, the participants used 'boundary negotiation' as a tool to frame their identities. Their professional identity was constructed through a range of discursive practices that vary in the different contexts in which they practise, and in relation to different audiences (Foley, 2005). Besides the common boundary work conducted between occupations (midwifery and medicine), the study also revealed intra-group negotiation between different types of midwives, e.g. licensed midwives, certified nurse-midwives, traditional midwives (Foley, 2005). Similar intra-group boundary negotiations (between senior and junior midwives)

were also identified in Hunter's (2005) study on emotion work and Purkis' (2006) study on transitional learning of newly qualified midwives. Within these studies, the midwives' ideological position, which underlies their practices between the medical and midwifery model, are viewed as the root cause of intra-group differences and conflicts. This brings about another manifestation of medical oppression: 'Cultural Imperialism' (Young, 1988), which is discussed in relation to the ideology underlying midwifery practice.

3.4.4 Ideology underlying Midwifery Practice and Professional Identity

'Cultural imperialism' goes beyond the structural and institutional power of the dominant group (Young, 1988). It emphasises the ideological power of the oppression. That is, the ideology of the dominant group becomes the governing norm, rendering the oppressed group subordinate and their characteristics invisible (Young, 1988). As happened in contemporary Chinese midwifery (discussion in section 2.4.4 and 2.4.5), a major theme repeated throughout the literature in relation to the definition of midwifery is the conflict between the midwifery and medical model of childbirth in midwifery practice (Annandale and Clark, 1996, Page, 2010). In accordance with 'Cultural Imperialism', the dominant use of the medical model in childbirth is seen as blurring the boundaries between midwifery and obstetrics in practice. As a result, not only is the public image of the midwife relegated to an 'obstetric nurse' and an 'obstetrician's assistant' (Goodman, 2007, Harris et al., 2009), but its professional identity has also been rendered ambiguous to the profession itself (Lane, 2002).

Van Teijlingen (2005) has systematically compared the medical and social models of childbirth (the midwifery model is categorised as a social model in his analysis) on three different levels: (1) the practical; (2) the ideological and (3) the analytical. When analysing the two models at the ideological level, Van Teijlingen (2005: 10.2) asserts that "ideology can be regarded as rhetorical, but not necessarily as uncritical of the subject's own way of working". Ideology in this sense serves as 'political dogma', in that the medical and midwifery models represent competing ideologies

of childbirth, assuming control over knowledge and defending or propagating the practices of each (Van Teijlingen, 2005: 10.2). Although Van Teijlingen (2005: 13.1) contends that the two models are mutually exclusive at the ideological level, he also acknowledges that, in practice, individuals “borrow aspects from both perspectives” to serve their purpose, as identified in Foley and Faircloth’s study (2003). In this study, twenty-six direct-entry, licensed midwives and certified nurse-midwives in the State of Florida were interviewed. It was established that, rather than placing the medical model in absolute opposition to the midwifery model, these midwives were pragmatic in their approach, moving fluidly between the two models and employing the discourse of medicine as the source of their ‘narratives of legitimation’ for the profession of midwifery (Foley and Faircloth, 2003: 165). Three types of discursive practices used by midwives to validate their profession are identified as follows: (1) drawing upon medical discourse as a contrast device to differentiate themselves and their practice from the medical establishment; (2) using the medical model to justify the necessary practice of their daily work; (3) constructing a discourse of collaboration to position themselves equally with obstetricians (Foley and Faircloth, 2003). From this perspective, being located at the intersection of the two models in everyday practice, midwives can adopt a mixture of midwifery and medical discourse to legitimate their profession.

In addition to the discursive use of the medical model for the purpose of legitimising the ideological claims of the midwifery profession, Van Teijlingen’s (2005) analysis also proposes a separation between the individual practitioner’s practices and the collective ideology of the profession. By quoting from DeVries (1993: 132), Van Teijlingen (2005) argues that, in practice, midwives are situated somewhere along a continuum between each model.

If we organised midwives along a continuum, with those who use all the tools of modern technology at one end and those who are non-technological in orientation at the other, those on the extreme ends of the continuum would not recognize each other as members of the same occupation. (DeVries, 1993: 132)

From this viewpoint, the practice of individual midwives is subject to the ideologies underlying the two models, resulting in diverse ideological positions for members of the profession. The ideological influence of the medical model upon the meaning of being a midwife is noted in Langton's (1991) study of the relationship between ideology and occupational identity in American nurse-midwives. With reference to the nurse-midwives' dependence on the medical model in practice, Langton (1991) identifies three types of occupational ideologies: dependent, interdependent and independent. Langton further reasons that each occupational ideology serves as a frame of reference, representing different occupational identities of the nurse-midwives: nurse, nurse midwife, and midwife. This is reflected in the fact that members of the midwifery group have "developed conflicting ideologies that have been useful in determining the direction of the occupation" (Langton, 1991: 171). Compared with Langton's study, Van Teijlingen's (2005) statement is more specifically documented by Lane's (2002) empirical study, in which she interviewed twenty-two midwives in different work settings in order to explore the ways in which the midwives' self-identity is constructed in relation to the competing midwifery and medical discourses. Viewing midwifery as a discursive practice, through which midwives draw on the discourses from both the midwifery and medical models to construct their practice, Lane (2002: 26) classifies the midwife participants into three types: 'obstetric-assistant', 'autonomous' and 'hybrid'. The majority fell into the 'hybrid' category. However, rather than situating them somewhere along the continuum between the two models as DeVries (1993) and Van Teijlingen (2005) assumed, Lane (2002) establishes that the ideological position of the 'hybrid' midwives is a dynamic one, depending on the contextual factors.

In Lane's (2002) study, the midwives' blending or 'hybrid' practices are grounded in the individuals' own manner of understanding childbirth, which has become their own ideology that guides practice and formulates an individual's professional identity. This 'hybrid' midwife is more akin to Davis-Floyd's (2007: 705) definition of the ideal 'postmodern midwife' as:

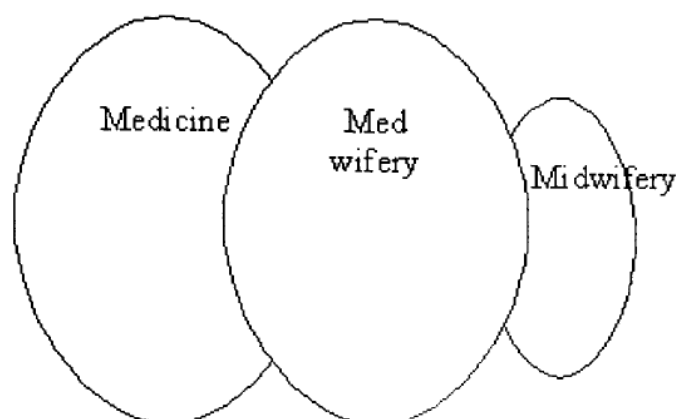
one who takes a relativistic stance toward biomedicine and other knowledge systems, alternative and indigenous, moving fluidly between them to serve the women she attends.

However, in most studies relating to the midwives' professional identity construction (particularly in hospital settings), the blending practices are largely a product of midwives' compromise to the medical dominance and institutional power. As a result, these midwives have developed a hybrid identity, but experience identity ambiguity. For example, in Hunter's (2004: 261) study, two conflicting ideologies of midwifery practice are identified, based on the settings in which midwives worked (community and hospital), these being: 'with woman' and 'with institution'. The contradiction between the 'with woman' ideology and 'with institution' reality is associated to the emotion work in midwifery. In Hunter's (2004) study, the negative emotions derived from the conflicting ideologies were particularly significant for the integrated team midwives, who worked in both hospital and community settings. These midwives were often placed in an ambiguous position when trying to apply the 'with woman' ideology in a work context where they were driven by the needs of the institution, leading to the development of ambiguous occupational identities. The ambiguous identity is more explicitly reflected in Rosenfeld and Foley's (2007: 2) study. As one solution to coping with the stress resulting from competing ideologies in midwifery practice, the hospital-based midwives study chose to embrace 'aspects of the medical model' while 'working against the self'.

As for the impacts of medical imperialism upon identity formation in midwifery practice, particularly in relation to the blurring boundaries between the two models in hospital settings, Purkis' (2006: 113) neologised 'Medwifery' makes it explicit. To explore how the 'practice associated learning' can shape the meaning of midwifery for the newly qualified midwives in hospital settings, Purkis (2006) employs the concepts of 'communities of practice' and 'legitimate peripheral participation' to frame her research. She (2006) reveals the transitional learning experiences of newly qualified midwives were involved in the practice at the boundary of

midwifery and obstetrics. Purkis (2006) terms this boundary practice as 'medwifery', by which she intends to define a practice dominated by obstetric norms, and by extension to offer a conceptualisation in terms of identity formation. Considering the imbalance of power between midwifery and medicine, Purkis (2006: 113) presents 'medwifery' in the following diagram (Figure 1).

Figure 1: The Balance of Power in 'Medwifery'



Purkis (2006: 114) illuminates the fact that the “symbiosis of the two communities is crucial to the identities that midwives are able to either construct or resist”. In the current context of China, evidence has demonstrated that medical dominance is well-entrenched in the institution of maternity care, as well as in public opinion (Harris et al., 2007, Cheung, 2009, Xing Lin et al., 2012). Together with the medically oriented training and on-going practices, hospital-based Chinese medwifery practice has been mixed with obstetrics (Cheung, 2011). Recently, (as discussed in Section 2.4.5), discourse concerning midwifery appears to be reviving and encroaching into the dominant medical discourse in the maternity care system, yet remaining mainly at the academic level. It may be seen that contemporary Chinese midwives’ professional identity is constructed at a certain ‘symbiosis’ of midwifery and medicine, where medicine plays a dominant role by exercising its structural and ideological power over midwifery.

3.5 The Research Focus

The foregoing text has analysed the literature on professional identity and midwifery pertinent to this study. Compared to the research on professional identities in other disciplines, in midwifery literature there were only a few empirical studies explicitly engaging in this subject. Findings from previous research in the international context of midwifery have provided insights into the issues that have a bearing on midwives' professional identity construction. However, when locating this subject in the context of contemporary Chinese midwifery, its marginalised professional status (particularly its currently subsumed position within the nursing profession) and the medical dominance in midwifery practice, form its own context for hospital-based Chinese midwives to construct their professional identity, but remains a fertile area for exploration.

This thesis therefore extends the existing studies on midwifery and professional identity in order to explore the ways in which hospital-based Chinese midwives construct their professional identity within the contemporary maternity care system. As a collective discourse on the profession, the constructs employed by midwives to describe their professional identity are identified. The process through which individual midwives construct their professional identity in hospital settings, along with the factors that influence this process is explored.

The broader research questions that I sought to answer are formulated as followed:

- What constructs are drawn on by hospital-based midwives to define their professional identity?
- How do midwives construct their individual professional identity in hospital settings?
- What factors contribute to the construction of individual professional identity in hospital-based midwifery practice?

CHAPTER FOUR: METHODOLOGY

4.1 Introduction

This chapter discusses and demonstrates the methodological journey that I went through to answer the research questions. Here I explain the choice of qualitative research design and grounded theory approach for this study. In the discussion on grounded theory, the variety of grounded theory families is examined and the rationale of choosing Constructivist Grounded Theory (CGT) for this research is justified. The reflexivity of my position in the research is discussed. The detailed process of data collection, management, translation and analysis are explained. The ethical issues, the quality and the limitation of this study are considered at the end.

4.2 Qualitative Research Design

A journey begins before the travellers depart (Charmaz, 2006: 1)

Charmaz's statement reflects very much my own research journey. This study aims to examine how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. To answer the research questions developed from my personal inquiry and the under-explored area in the existing literature, I started to seek an appropriate research design and prepare for the journey before departure.

The essential principle for choosing a research approach is to see how it best fits answering the research questions (Flick, 2002). A qualitative approach is typically suitable for the studies aiming for an in-depth understanding of the subject under exploration. It concerns meanings embedded in people's experiences rather than testing predictions (Bryman, 2008). A qualitative approach can enable the researcher to locate the study subjects in a natural setting and to make sense of their experiences by embracing the participants' own perspectives and the context in which they are situated (Charmaz, 2008, Hennink et al., 2011). Central to this

study is exploring how the hospital Chinese midwives construct their professional identity through the interpretations of their everyday experiences. The meaning that individuals give to their experiences is essential to be studied in its natural form, which can be achieved with the support of a qualitative research design. By this methodological means, the contextual influences on the research topic can also be identified and understood. Additionally, a qualitative approach has been predominantly used in the existing literature for the research inquiries regarding professional identity construction (Brott and Myers, 1999, MacIntosh, 2003, Beijgaard et al., 2004, Phillips and Hayes, 2006).

For these reasons, a qualitative design was considered to be the best fit for the aim of this thesis. However, qualitative research is a broad term, embracing a range of qualitative methodologies underpinned by different philosophies, procedures and techniques (Willig, 2008, Hennink et al., 2011). The previous empirical studies on professional identity construction implied that five qualitative research approaches were primarily adopted to explore this topic. These are: grounded theory, phenomenology, narrative research, ethnography and case study. The adoption of each was based on the aims of the researcher and the nature of the research inquiry.

Many scholars (e.g. Bryman, 2008; Holloway and Wheeler, 2010) have introduced and illustrated these qualitative approaches in terms of their focus and practical use in research. Amongst these methodological introductions, Creswell (2007: 81) thoroughly compares the above five approaches and outlines the major differences between them on the basis of 'the focus, the type of research problem addressed, the discipline background, the unit of analysis, the forms of data collection, data analysis strategies, and the nature of the final written report' (for the detailed comparison, see Appendix B). Considering the focus and type of the research problem that the current study aimed to address, the development of an explanatory theory from the views of the study participants was the primary objective of this research. Therefore, comparing with other qualitative approaches,

such as phenomenology that aims to capture and describe the essence of the lived experience of a phenomenon; narrative research that needs to explore the individuals' experiences through their life stories; ethnography with the purpose of describing and interpreting the patterns of a cultural group; or case study that focuses on developing an in-depth understanding of individual case or cases, Grounded Theory (GT) was chosen as the best fit to achieve the objective for this study. A thorough justification for choosing GT approach is presented in the following section.

4.3 Grounded Theory

Grounded Theory (GT) was originally developed by Glaser and Strauss (1967: 1) in 1967 in their book *The Discovery of Grounded Theory*, being defined as 'the discovery of theory from data', with its characteristics being exploratory and inductive. That is, hypotheses are not preconceived but derived from data and continually evaluated by means of constant comparison until a theory is developed to explain the research subject under study (Glaser and Strauss, 1967). The major purpose of GT approach is to explain how people address issues that they experience as problematic in their world (Glaser, 1978). It locates research problems in a social context and explains how people process and deal with this problem via theory inductively developed from the grounded data (Glaser and Strauss, 1967, Mills et al., 2007, Charmaz, 2008).

As such, a GT approach allows an inductive exploration of how the hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. It can facilitate an in-depth understanding of the individual midwives' constructions of their professional identities, grounded in their interpretations of midwifery experiences. It can also enable the construction of theoretical categories from the participants' own words that ensure the developed theory mirrors the social context where contemporary Chinese midwives are located. In addition, GT approach is a useful means to explore a topic of interest or

problem area that is under-explored (Strauss and Corbin, 1998). It is thus particularly appropriate to this study, as little is known about this research inquiry in the existing literature as discussed in Chapter Three.

Apart from choosing GT to guide this study, in light of the different philosophical stances underlying GT, it is necessary to take a look at three important versions within GT families.

4.3.1 Different Versions of Grounded Theory

GT has evolved over time in the past four decades with its roots in work by Glaser and Strauss (1967) and has become a widely accepted qualitative approach. However, the evolution of GT has provoked debates focusing on whether the later developed versions strictly adhere to its original intent of 'discovery of theory from data' e.g. (Glaser, 2007, Mills et al., 2007, Rupsiene and Pranskuniene, 2010). In terms of the methodological differences among the variations of grounded theorists, their underlying philosophical positions are at the centre of the debate. As Mills et al. (2006: 72) pointed out, the evolution of GT can be seen as a 'methodological spiral' and at its various loci grounded theorists adapt their versions of GT to fit with their philosophical orientations.

The classic grounded theory (Glaser and Strauss, 1967) emphasises the 'discovery' nature of the approach, which indicates that 'the researcher uncovers something that is already there' (Charmaz, 2008: 45). As such, the position of the original grounded theorists has been argued as remaining close to positivism (Charmaz, 2008), with its epistemological roots in objectivism. Their concept of 'emergency' is challenged by latter researchers as 'playing down the creative role of the researcher in the research process' (Charmaz, 2008: 45). It can be seen in the divergence of using GT that emerged later between the two founders (Charmaz, 2006), as Strauss and his student Corbin (1998) move into post-positivism and are positioned in a mixed epistemological stance: an objectivism enabling unbiased data collection and

a social constructivism acknowledging the involvement of the researcher in concept construction (Dey, 1999, Charmaz, 2003). Underlying the philosophical divergence, the central methodological split between Glaser and Strauss is that Glaser retains consistency with the original GT approaches in the direction of the comparative methods, while Strauss and Corbin's version focuses on the use of specific coding paradigms, such as an 'axial coding paradigm' and a 'conditional matrix' (Charmaz, 2008).

In the past two decades, GT has gone beyond the controversy between the two originators and stepped into the second generation (Rupsiene and Pranskuniene, 2010). These researchers aim at taking the originators' invitation to adapt their GT strategies in a flexible way. The first substantially modified version is Charmaz's (2000, 2006) Constructivist Grounded Theory (CGT). In accordance with the social constructivism paradigm, constructivist grounded theorists hold a reflexive viewpoint on the modes of knowing. They view the truth as being emerged through the construction of people's experiences, their interpretations of the experiences and the meaning they give to the experiences (Guba and Lincoln, 1994). Therefore, the interaction between participants and researcher is of concern in this GT version, acknowledging that theory is constructed through such interaction rather than objectively emerging or being discovered (Charmaz, 2006, 2008).

While examining the different versions within GT families, Dey (2004: 80) has come to the conclusion that 'there is no such thing as "grounded theory" if we mean by that a single, unified methodology, tightly defined and clearly specified'. Rather, these variations are situated on a GT family continuum, with one end being Glaser's (1978) objective position and the other end being Charmaz's (2000, 2006) constructivist stance with regard to the data.

4.3.2 Constructivist Grounded Theory

According to Crotty (2011), any research process needs to address four elements before departure: epistemology, theoretical perspective, methodology and methods. The links among these elements need to be congruent when generating a GT to ensure a strong research design (Ghezeljeh and Emami, 2009). When seeking which form of GT to undertake, it needs to be made clear where I, as a researcher, fit within the GT family. For this thesis, my position is closer to the constructivist end on the continuum of the GT family for the following reasons.

Firstly, due to my relationship to some of the participants, my past research and practising experiences in maternity units and my preconceptions of the research area, I acknowledge my role as a researcher in the research process as Charmaz (2006) and Strauss and Corbin (1998) do. That is, as a researcher, my interaction with the participants and my interpretation of the data at the later stages of analysis is part of the research process (Charmaz, 2008). This constructivist methodological stance allows me to position myself closely with the data and facilitates my theoretical sensitivity to the research inquiry. Theoretical sensitivity is described as a required capacity that GT researchers need to possess. It comprises of the level of insight into the research area, acuity to the nuances of the participants' words and actions, and the ability to sort out pertinent information from the data generated with the participants (Mills et al., 2006). Taken from this view, my past experiences and pre-knowledge of the research area can keep me remaining sensitive to the data with an open mind rather than 'an empty head' (Dey, 1999: 251). In the meantime, the characteristics of this approach can also help me to keep reflecting on my preconceptions of the study subject, my role in the research process and its impact upon knowledge creation by documenting my reflections throughout the research (Charmaz, 2006). My reflection during the research process is discussed in Section (4.3.3).

Although Glaser and Strauss and Charmaz's versions of GT vary in their philosophical underpinnings, Charmaz (2006: 5) contends that they share the following practice guideline:

- Simultaneous involvement in data collection and analysis;
- Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses;
- Using the constant comparative method, which involves making comparisons during each stage of the analysis;
- Advancing theory development during each step of data collection and analysis;
- Memo-writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps;
- Sampling aimed toward theory construction, not for population representativeness;
- Conducting the literature review after developing an independent analysis.

From the methodological perspective, constructivist grounded theorists carry forward this traditional GT guideline as a set of principles rather than a fixed prescription (Charmaz, 2006). The way that constructivist grounded theorists use this guideline is applied to this research in that I followed the basic principles whilst maintaining flexibility through the research process (see Research Method Section 4.4).

4.3.3 Reflexivity

Charmaz (2006) and Strauss and Corbin (1998) argue that it is not possible to disassociate ourselves from who we are and what we already know. These preconceptions are inherently derived from our values and experiences being influenced by the wider social context. Although I have never been employed as a

midwife, I have over four-years' research and teaching experience been involved in the area of maternal and newborn care. As such, I have worked closely with maternity care practitioners in the hospital setting, thus potentially share a certain level of experiences with the study participants.

For these reasons I agree with Charmaz's (2006) statement that the construction of GT is related to my relevant experiences in the past, and present experiences in the interactions with the whole research process. In light of this, I consider my perceptions and knowledge, as well as experiences in maternity care and research, as a resource that expands my insights into the research inquiry and increases my sensitivity to the data. Meanwhile, to retain openness to the data under study, reflexivity on my background assumptions and my interactions with the data is vital. Throughout this study I acknowledged and continually reflected on this previously gained knowledge and how these assumptions might impact upon my role in the study and research process. Such reflexivity was documented in my research memos along with my analytic processes in order to facilitate my theoretical sensitivity to the developed concepts whilst not 'forcing our explanations on the data' (Strauss and Corbin, 1998: 47).

4.3.3.1 The Development of My Personal Understandings of Midwives' Professional Identity

When I was at school, I was educated in a nursing programme and became a general nurse after graduation. My initial contact with midwives happened during my master's study. For three years, I conducted my master's project working in one maternity unit of a tertiary hospital in the central area of China. During that time, I worked closely with midwives and witnessed their ambiguous role in the workplace. In that maternity unit, there were only four qualified midwives. These midwives' routine work was primarily maintaining labour wards, observing labour processes and assisting obstetricians to deliver babies. Because of the high caesarean section rate, the number of vaginal births in that unit was low. As the assessment criteria

for resident obstetricians involved their work in labour wards and numbers of baby deliveries, these obstetricians undertook most of the vaginal deliveries, while midwives took on their role only when the obstetricians were unavailable. In that unit, those midwives seemed to accept such situations as routine. These experiences gave me an impression that the scope of midwifery practice was in labour wards, midwives were almost invisible in the maternity care system, and the role of the midwives was replaceable.

After completing my master's studies, I started my academic career in a university, conducting teaching and still doing research in the field of maternal and newborn care. At that time, as midwifery had already become a sub-branch of nursing and obstetricians played a leading role in maternity care, I didn't pay much attention to the midwives. My interests in this specialist group have been generated by my later experiences of attending several midwifery conferences and informal conversations with my friends – several of whom are midwives. These experiences made me look again at the current status of Chinese midwifery and I found that midwives were struggling with their current professional status and feeling troubled about their position in the contemporary maternity care system. It was disturbing to see the unfavourable institutional environments, where there are no specific legal rules or statutory body specifically for midwives and the title of midwives is not protected by law. Obstetricians took over most of the midwives' role in normal births and midwives were ultimately being assigned to the nursing group. These past experiences and understandings motivated me to see how hospital-based midwives perceive themselves and what their professional identities are in the contemporary Chinese maternity care system.

When preparing the research, I reviewed the literature on the subject of professional identity and midwifery. Previous theoretical knowledge and empirical research have increased my understanding of the role of midwives, their responsibilities and obligations, their indispensable role in maternity care, the professional status of midwifery on the international stage and the significance of

exploring professional identity for a professional group. With these personal and theoretical preoccupations, I assumed that Chinese midwives may passively accept the institutionally assigned nurse identity and play the corresponding roles as they are placed in a marginalised position in the maternity care system. As the study progressed, my understanding of midwives' professional identity has developed. Not only have the midwife participants expressed a sense of resistance to the institutionalised nurse identity, they have also developed certain strategies to actively enact their ideological claims to the profession. The data of this study present midwives' ideological claims to the profession as well as how the individual midwives enact these ideological claims, which enabled me to understand the hospital-based midwives' professional identity construction from both a professional and individual perspective.

In addition, the understanding of myself in this research process has also developed throughout the study. At the beginning of this study, with pre-experiences and knowledge of the midwife, I considered myself as an insider who could understand, share and empathise with the midwife-participants' views, perceptions, values and emotions. However, in the actual fieldwork I found myself playing different roles and presenting different aspects of the self in the interactions with my participants (explained in Section 4.3.3.2).

4.3.3.2 My Position within the Research Process

In taking a constructivist stance in GT, the role that the researcher plays needs to be acknowledged not only in the process of interpreting the data, but also in the fieldwork in order to maintain the trustworthiness of the findings (Charmaz and Mitchell, 1996). In essence, reflexivity is a constant process that needs to be conducted throughout qualitative research, which was fundamental to this research project and directly associated to my position within the research process. Having past experiences and knowledge of Chinese maternity care I was not a novice interviewer exploring an entirely unknown area. In this sense, I considered myself as

an insider. However, conducting teaching and research in maternal and newborn care whilst not being employed as a qualified midwife, I was in the meanwhile an outsider to the midwives' inner world. How I presented myself and how I was perceived by the participants was important as it could exert an impact on the collected data. It was therefore important to identify my position when faced with participants. With reference to Reinharz's (1997) different facets of 'selves', I reflected on my various selves in the research:

- The research-centred selves: being a PhD student in midwifery; being a MSc in obstetric nursing; being a researcher in maternal and newborn care; being an interviewer.
- The brought selves: being female; being an overseas student in the UK; not being native to the area where the research was conducted; being a nursing teacher.
- The situationally generated selves: being an insider (with the experiences of working with midwives in a maternity unit and theoretical knowledge in midwifery); being an outsider (an academic teacher, registered nurse in maternal and newborn care and a researcher); being a listener and a friend.

My different 'selves' within a research situation had close relation to the participants' motivations to engage. Due to the above different selves that I held, I discreetly presented the various aspects of myself in the research process whilst constantly reflecting on its impact on the process in order to gain rich and unbiased data for the study, and at the same time to bear the ethical issues in my mind. Within each research scenario the representation of my different selves was dynamic, allowing the co-construction of 'who we are' between the participant and I during our interaction (Reinharz, 1997). After each interview, I wrote a research diary to reflect on my interaction with the participant and the influence of my role. It is through the reflexive process that I become aware of, and able to manage,

these different identities in the research setting. An example of my positioning in interviews is presented in the following section.

4.3.3.3 An Example of My Positioning in Interviews

To take the example in the interview with a newly qualified midwife – while I tried to posit myself as a researcher in the field, she viewed me more as a PhD student learning in the UK with advanced knowledge in midwifery care. My expected mutual and equal relationship consequently turned to be unbalanced with her in an inferior place. At times she even viewed me as a representative of advanced midwifery care in developed countries by berating current maternity care in China while assuming midwifery care in the developed country is almost perfect. Since the study approach is constructive in nature, I tried to be interactive with the participant in order to facilitate more complete knowledge of her experiences and perceptions in relation to my research inquiry. Therefore, when she consulted me on how certain aspects of midwifery care work in the UK, I told her of some similarities between the unsound situations in midwifery care for Chinese midwives and midwives in the UK. When she learned that she shared more or less similar negative experiences with her foreign counterparts, she began to interpret her experiences in a more insightful way. For example, she tried to identify and analyse the problems underlying the current maternity care system and reflect on and evaluate the progress of midwifery development in recent years.

At the same time, I told her I am the same age as her, and posited myself as her peer in order to redress the balance of power and facilitate her ability to speak more freely and be more involved. In addition, I let her know my genuine interest in her experiences as I believed that she felt comfortable talking to me as a result of this. I didn't present my teacher identity to her in that this identity had less relevance to the study. Most importantly I was worried this 'self' would affect our established relationship and make her feel uncomfortable, as the identity of a

nursing teacher in university may represent a possible hierarchy for a newly qualified midwife who just graduated from a technical secondary school.

Interestingly, while researching the subject of identity, I was also engaging in a process of identity construction and negotiation during the course of this study. My reflections of negotiating the multiple selves in the research process have also assisted the development of my theoretical sensitivity to the research subject.

4.4 Research Methods

This section details how the principles of grounded theory approach are practically applied in this study. It begins with the illustration of data collection procedures including the research setting, practical issues in the process of participant recruitment, sampling and data collection methods. The data management and translation issues follow. The demonstration of the data analysis process is then presented.

Data collection for this study lasted eight months from October 2010 to May 2011. Fifteen midwives and five women participants were recruited. Ethical approval was obtained from the Ethics Committee at the University of Edinburgh and the Academic Committee in Hangzhou Normal University of China. Participants were approached through personal contact, when necessary, the permission to access the participants (midwives and women) was obtained from the relevant gatekeepers in the hospitals and community health-care centre (for detailed recruitment procedure see section 4.4.2). All participants gave their informed written consent to participate in the study. For the informed consent forms see Appendix J. In order to maintain anonymity and confidentiality, the research setting, participants and their workplaces described in the following text are all given pseudonyms. Full ethical consideration is discussed in section (4.5).

Although the research process is discussed in a linear form in the following sections, in practice the process was iterative in manner. As Gerson and Horowitz (2002: 200) claimed, the typical qualitative research process is not straightforward but involves 'facing problems out of order and coping simultaneously with a variety of methodological and theoretical conundrums'. This is particularly the case for GT study (Charmaz, 2008). This whole research project was like an iterative journey as I stepped back and forth between data collection, analysis and reflection on literature; even the research question was open to adjustment. Yet, the cyclical nature is the significant advantage in GT, allowing me to follow the theoretical hints to respond to the data and to adjust the research design.

4.4.1 Research Setting

This study was conducted in a capital city (Eastern City, pseudonym) of a province in China. Under the jurisdiction of Eastern City there are eight districts, three county-level cities and two counties. According to the five per cent population sampling survey in 2009, the population of long-term residents in Eastern City was 8.1 million and the birth rate of the population was 9.18 per cent (Statistics., 2009). However, there was no record of the statistics of midwives in this city. According to a random sampling survey on the current status of maternity care conducted by the Chinese Ministry of Health in 2008, there were four midwives per 100,000 people in this region of China (Tan, 2010). With reference to this survey, the rough estimated number of midwives in Eastern City was about 324 by 2008.

As introduced in Chapter Two (Section 2.4.3), the qualified midwives in contemporary China are mainly employed in hospital settings. Hospitals are classified into three organisational levels with tertiary hospitals (Level 3) at the top and primary hospitals (Level 1) at the bottom, according to the hospital classification standards stipulated by the Chinese Ministry of Health (1989). The ranking criteria are based on geographic location, level of specialists and quality of services (Cheung et al., 2009):

- A primary hospital (Level 1) is the primary health-care institution which directly provides primary medical treatment, prevention, health care and rehabilitation to the local community and is located in rural communities and city districts;
- A secondary hospital (Level 2) is the regional hospital which provides a number of communities with comprehensive medical and health services and is located in the region, county and city;
- A tertiary hospital (Level 3) is the comprehensive or specialist hospital which provides advanced medical and health services nationwide. The tertiary hospital also takes a role in higher education and research.

In Eastern City, qualified midwives were only found in the secondary and tertiary hospitals. Throughout the sampling process, midwives from three types of hospitals were recruited to explore their experiences in a mixture of working contexts, including one tertiary maternal hospital (TMH: a specialist hospital) and one tertiary general hospital (TGH: a comprehensive hospital) in the central area of the city, and four secondary hospitals (SH) in suburban areas. Women who received midwifery service from the hospitals (TMH and TGH) were recruited to the study. The descriptions of the midwife participants' work settings are presented in Table 1 and the detailed sampling process is discussed in the following sections.

Table 1 Summary of the Working Context

Tertiary Maternity Hospital (TMH)			
Name of Hospital	TMH	Ranking	Tertiary
Average Number of Childbirths in 2010	10,000	Number of midwives	50
Description: The hospital is a leading specialist maternity hospital with prevailing advanced medical technology and a well-known, high quality of medical service. There are five maternity wards, one labour ward and one neonatal intensive care unit (NICU). This unit is operated under an obstetric-led model. The accounts of these midwives were expected to reflect how they construct their professional identity under a medical model.			

Tertiary General Hospital (TGH)			
Name of Hospital	Tertiary General Hospital (TGH)	Ranking	Tertiary
Average Number of Childbirths in 2010	6,000	Number of midwives	42
Description: The hospital is a comprehensive hospital. There are three maternity wards and one labour ward in the obstetric department of the hospital. Maternity care is mainly operated under an obstetric-led model, while a midwife-led labour room was implemented, which is popular with the labouring women in Eastern City. Midwives in this hospital were expected to compare their experiences in two different models of care (the obstetric-led model and midwife-led model), giving insights into how they construct their professional identity in a context with a mixture of ideology of care.			

Secondary Hospital (SH)			
Name of Hospital	Secondary Hospital (SH)	Ranking	Secondary
Average Number of Childbirths in 2010	2,500	Number of midwives	10
Description: These hospitals are secondary general hospitals located in the suburban area of Eastern City. In these hospitals, obstetrics and gynaecology are not separate departments. Maternity care is operated under an obstetric-led model. The midwives there work mainly in labour wards; occasionally in obstetric wards and gynaecology wards and the newborn room. Midwives in these hospitals were expected to share their different insights into how they construct their professional identity in secondary hospitals.			

4.4.2 Process of Recruitment

Gaining access to participants often takes more effort than expected as many practical and ethical issues need to be borne in mind. The detailed recruitment process is presented as follows.

4.4.2.1 Access to Midwife Participants

Because there is no midwifery registration data in the research setting, I couldn't access the name or contact information of the midwives directly. A common approach in nursing and midwifery for recruitment is to get approval from the relevant gatekeepers, such as the manager of the hospital or a director in a nursing department. Although to some extent the gatekeepers may enhance the research credibility with their support (Sixsmith et al., 2003), such recruitment may also influence the way in which the participants provide information (Orb et al., 2001). On the one hand, there may be a selective recruitment of participants with the possibility that only the one who is likely to speak positively is recruited. On the other hand, participants may feel obliged to take part whilst potentially finding it difficult to be completely honest in the interview.

Considering the potential impact of the management issues upon recruitment, I tried to gain access to the prospective participants through personal contact at the initial stage of the fieldwork. Through this means I approached five midwives (Catherine, Linda and Emma in TGH, Emily and Juliet in TMH) whom I knew before. These midwives were approached according to the criteria of purposive sampling, sampling the 'significant individuals' (Cutcliffe, 2000: 1477), who are pertinent to the research questions and whose knowledge and experience can facilitate an in-depth analysis of the study subject (Bryman, 2008). These interviews set up the basis for further theoretical sampling (detailed the sampling method see Section 4.4.3).

After preliminarily analysing the initial five interviews, I started further recruitment. Since the two midwives (Emily in TMH and Linda in TGH) had participated in my study and have managerial positions, I asked them to distribute my information sheet (see Appendix I) to their staff midwives in order to attract any potential

participants. However, because of midwives' workload and frequent day and night shifts, the research information sheets did not attract any volunteers. In order to recruit more participants, I had to adjust my recruiting method to approach midwives more directly. With the help of Emily and Linda, I accessed the contact information of the staff midwives in their units and tried to invite those who fitted the theoretical sampling criteria of the study (for an illustration of theoretical sampling process see Section 4.4.3). After making several phone calls to invite these midwives to participate in the study, six midwives from TMH and TGH (Mary, Ellen, Yvonne, Fiona, Lena and Daisy) were recruited.

The access to the midwives from the secondary hospitals (SH) was through the help of Linda. The maternity unit (in TGH) where Linda works was undertaking clinical refresher training for midwives from secondary hospitals, especially in suburban or rural areas. After Linda gave me this information, I asked her to distribute my research information sheet to those midwives when they came for clinical training. I then invited them to the study by explaining my research through phone calls. Four midwives (Jessica, Jenny, Maya, Anne) were recruited by this means. The profiles of the midwife participants are summarised in Table 2.

Table 2 Profiles of the Midwife Participants

Hospital	Name	Post	Educational Background	Employment before Midwife (years)	Years of Midwifery Practice
TMH	Emily	MM	Midwifery	—	25
	Juliet	—	Nursing	GN(1)	3.5
	Mary	—	Nursing	ON(5)	4
	Lena	—	Nursing	—	3
TGH	Catherine	MM	Midwifery	—	36
	Linda	MM	Midwifery	—	26
	Emma	—	Midwifery	—	3.5
	Ellen	—	Midwifery	—	20
	Yvonne	—	Nursing	ON(9)	3
	Fiona	—	Nursing	ON(8)	4
	Daisy	—	Midwifery	—	3
	Jessica	—	Midwifery	GN(1)	11
SH	Jenny	MM	Midwifery	GP(10)	6
	Maya	—	Nursing	GN(1)	9
	Anne	—	Midwifery	—	10

Notes: TMH (Tertiary Maternity Hospital), TGH (Tertiary General Hospital), SH (Secondary Hospital); MM (Midwife with Managerial Position); GN (general nurse); ON (Obstetric nurse), GP (general practitioner in obstetrics and gynaecology).

Throughout the recruitment, only one participant from secondary hospitals refused because she was transferred from nursing to midwifery care for only three months. She told me that she didn't have enough midwifery experiences to share with me. The other participants whom I initially contacted all participated in this study. The underlying reason for the high response rate may be in that some of them were willing to talk to me because they wanted to share their experiences and make their voice heard, or the midwives, whom I knew before, have felt obligated to help me; while others may have felt authoritative pressure from their managers. Bearing such potential ethical issues in mind before the outset of the fieldwork, at the initial phone contacts I spent more time to explain the information of this study to the prospective participants, assure them of their voluntary-based participation and

carefully selected the interview time and venue to suit them. Before the interview, I clearly explained their right to withdraw from the study at any time without any harm, reassured them of the anonymity and confidentiality, and made effort to establish a rapport with the participants.

4.4.2.2 Access to Women Participants

The selection of women clients for the study was decided during the theoretical sampling stage based on the categories developed from the accounts of the midwife participants (see Section 4.4.3). The experiences and perceptions shared by women participants helped to add an additional perspective to the midwives' experience and the context where midwifery care took place. The recruitment criteria for the women participants were based on the categories grounded in the midwife participants' accounts. These were:

- Gave vaginal birth;
- Cared for by midwife/midwives during childbirth in the hospitals where the midwife participants worked;
- Cared for under the midwife-led room (midwifery model);
- Or cared for under the obstetric-led model (medical model).

In terms of the interview time with women participants, some researchers chose a time within 48 hours of delivery in an attempt to avoid the early period of 'elation' and 'maternity blues' e.g. (Bluff and Holloway, 1994). Others e.g. (Kuo et al., 2010) believe that it is beneficial for women as well as for the outcome of the interview to interview women when they go home. In the context of this study women stayed in hospital for four days after birth. Considering that the hospital circumstances and the women's condition were not suitable for a one-hour length interview, I chose to interview the women at their homes after they were discharged from hospital. In

this way, women participants would feel safe and comfortable and may be prepared to be more open about their experiences. In addition, to maintain women's clear memory of their experiences in hospital, I decided to interview them during their postpartum period (within 28 days after giving birth).

In China, when mothers are discharged from hospital, their childbirth records are transferred to the local community health centre and they will be followed up by a general practitioner (GP) in that centre. Therefore, in order to approach the women participants I sought help through community health centres in Eastern City. Finally, I gained the approval from a manager in one community health centre to access the women's childbirth records there, from which I selected women who met the recruitment criteria to make phone contact. I made several phone calls to the potential participants, explaining my research aims and inviting them to join this study. When they agreed, we arranged the date and time for the interview. Finally, five women were recruited to the study. Their profiles are summarised in Table 3.

Table 3 Profiles of the Women Participants

Name	Age	Primiparity or not	Educational Background	Hospital for Delivery
Joanna	33	Y	Technical School	TGH (Midwifery M)
Claire	29	Y	University	TMH (Medical M)
Sophia	29	Y	University	TMH (Medical M)
Nancy	27	Y	University	TMH (Medical M)
Natalie	29	Y	Technical School	TGH (Medical M)
<i>Notes:</i> Midwifery M (Midwifery Model); Medical M (Medical Model)				

In this community health centre only the women who gave birth in hospitals (TMH and TGH) were identified. This was considered as one of the limitations for the recruitment. As the midwives in TMH and SH were under management of the similar care model (obstetric-led medical model) and shared similar perceptions of their relationships with women, the limitation with regard to the absence of women participants being cared for in hospital SH could be lessened. In addition, only the women with relatively higher education levels agreed to take part in the study. The

absence of less educated women in this study may be considered as another recruitment limitation. However, the participating women who volunteered and were well educated were more likely to be open and articulate their views, and share their experiences and perceptions of the midwives who cared for them.

In total, 20 participants including 15 midwives and 5 women were recruited and completed written consents as eligible to participate in the study.

4.4.3 Theoretical Sampling

Grounded theory is developed through constant comparison of data obtained from theoretical sampling, which entails this methodological approach its analytic power and grounds the developed theory in the data (Charmaz, 2006). However, Glaser (1978: 45) acknowledged that at the initial stage of sampling, researchers 'go to the groups which they believe will maximise the possibilities of obtaining data and lead for more data on their question'. It implies that the researcher does commence data collection with a sample recruited through the process of purposeful sampling. Theoretical sampling then begins when theoretical concepts emerge from the initial purposeful sample and guide further sampling processes.

By this means, at the initial stage I started the sampling process by interviewing 'significant individuals', who had 'the knowledge and the experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed and is willing to participate in the study' (Cutcliffe, 2000: 1477). Five midwives from two tertiary hospitals (TGH and TMH) were drawn purposively at the beginning of the fieldwork:

- One midwife with previous managerial position in nursing department (Catherine), one midwife with managerial position in the wards (Linda) and one staff midwife (Emma) in the maternity unit of a tertiary general hospital (TGH) were recruited;

- One midwife with managerial position in the wards (Emily) and one staff midwife (Juliet) in the tertiary maternity hospital (TMH) were recruited.

Through these interviews, the quality of initial data collection and analysis were examined by academic supervisors. The initial data from purposive sampling informed the generation of a range of categories, which are depicted as the 'building blocks of theory' (Strauss and Corbin, 1990: 102), directing my further data collection.

From the initial analysis, categories in terms of how these hospital-based midwives construct their professional identity were identified as 'medical preparation', 'role confusion', 'invisible public image', 'being with woman', 'focusing on the task', 'advocating normal birth', 'reducing the risk', 'women's dissatisfaction with care' and 'women's reliance on medicalised birth'. Theoretical sampling then targeted those who could provide information that enabled the developed categories to be explored in depth and breadth.

For example, the theoretical concepts 'medical preparation' and 'role confusion' directed sampling to recruit the midwives who entered into midwifery at different periods of midwifery development in contemporary China and from different preparation routes, including: the experienced midwives who had undergone midwifery transition in the period from being an independent profession to a sub-group of nursing; other midwives who started midwifery when midwifery was being subsumed in nursing; the direct-entry midwives and the nurse-midwives.

The concepts 'being with woman', 'focusing on the task', 'advocating normal birth' and 'reducing the risk' guided me to sample the midwives with different experiences of midwifery care and different environments of their working context. I thus further recruited midwives from the secondary hospitals (SH) in suburban areas, and midwives with different years of experience to expand the properties and dimensions of the emerging categories.

In addition, in the accounts of midwife-participants, they raised issues around the midwife image perceived by their women clients and how their relationship with women affected them in constructing a positive professional identity. 'Invisible public image' and 'women's individualised care needs' and 'women's reliance on medicalised birth' entailed the sampling of women participants, who gave vaginal birth and were cared for by the midwives, in order to gain additional perspective on midwifery experiences and the contexts where the midwifery care took place.

As explained, theoretical sampling followed these theoretical threads to seek specific subjects based on their potential to develop these categories. Such type of sampling acted as a self-correcting process in that through constant comparison in data analysis, gaps in the collected data emerged and directed the following sampling (Charmaz, 2002). By this means, later sampling continued to develop, enrich and finally saturate these categories (Strauss and Corbin, 1998). The criteria of saturation in grounded theory are different from the common use of saturation, which is identical to nothing new emerging (Charmaz, 2006), as Glaser (2001: 191) stated:

It is the conceptualisation of comparisons of these incidents which yield different properties of the pattern, until no new properties of the pattern emerge.

The categories were then deemed to be saturated when new properties of the categories relating to the original research questions were not revealed from the newly gathered data (Charmaz, 2006).

For instance, when developing the category 'medical preparation', the properties of this category developed from the data were the form and extent that the midwives were prepared medically. From the accounts of the direct-entry midwives and the nurse-midwives, two forms of medical preparation were identified based on their training contexts: the midwifery programme at school for the direct-entry midwives

(being dominated by obstetric knowledge) and the on-job training in hospital settings for the nurse-midwives (being managed under the obstetric-led model).

Further interviews revealed that under the school preparation for the direct-entry midwives, there were two sub-forms of the preparation model that represented different degree of their medical preparation at school: one is the quasi-obstetrician preparation model that was identified by the midwives who entered midwifery programme during the transitional period in the 1980s (from being a 'modern midwife' to an 'obstetric nurse'); the other is the midwifery programme that was heavily referencing to the obstetric textbooks commented by the midwives who entered midwifery programme after the profession was subsumed into the nursing group. Apart from the school preparation, the accounts from all the direct-entry midwives also indicated that their practical knowledge of midwifery was mainly gained through their later on-job learning in hospital settings. Such transitional learning was claimed to be under the obstetric-led model in the workplace, which was the same form of preparation model that was used to train the nurse-midwives.

For the category 'medical preparation', one direct-entry midwife (Emma) can be seen as a 'deviant case' in this study. Emma stated that she was prepared in a midwifery programme at school that was medically oriented as the other direct-entry midwives did. However, she was the only midwife participant, whose transitional learning was undertaken in a midwifery model of the hospital setting (the analysis of the case of Emma was detailed in section 5.2.1). Emma's case revealed a combination of the medical preparation at school and the midwifery transitional learning at the workplace. During theoretical sampling, the examination of such 'deviant cases' was vital for me to expand the dimension of the categories and to facilitate a fuller understanding of the phenomenon at a more abstract level (Schreiber, 2001). Via such theoretical sampling and the simultaneous analysis, when no new form and extent of the medical preparation emerged from midwife participants' accounts, the category 'medical preparation' was saturated.

Following this principle, I kept developing the categories pertaining to the research inquiry, till the properties and dimensions of all the theoretical categories were sufficient to generate a 'plausible' story (Melia, 1997). Finally, 15 midwife participants were recruited who were largely representatives of the hospital-based midwives in terms of experience, types of midwives, position and working context. The sample included midwives with different years of midwifery experience; direct-entry midwives and nurse-midwives; midwives with managerial experience and staff midwives; midwives who work in the tertiary maternal hospital (TMH), the tertiary general hospital (TGH) in the city centre, and the secondary hospitals (SH) in a suburban area (summarised in Table 2). Five women participants, who received midwifery services in the hospitals where the midwife participants worked were also recruited to validate and refine the theoretical model developed from the midwives' accounts. The women participants ranged in age from 27 to 33 and were all primiparas. One woman received care in the midwife-led labour room underpinned by midwifery model in TGH, while four others obtained care in traditional medical model in either TGH or TMH. Their postpartum weeks ranged from 1 to 4 weeks at the time of the interviews (summarised in Table 3).

4.4.4 Data Collection Method

Charmaz (2006) pointed out that methods alone do not generate good research, but effective methods could help answer the research questions in an insightful way. Taken from this view, the basic principle of choosing methods is to follow the research questions. With reference to the previous studies on professional identity construction, interviews, focus group discussions and written documents (such as reflective diaries) were the most applicable methods to gain a thorough understanding of the professionals' thoughts about their professional identity. Aiming at the details of participants' perceptions on the research subject and considering the practical issues in the research field, the in-depth interview was chosen as main method to collect data for the present study.

In-depth interviewing is like grounded theory, as it is 'open-ended but directed, shaped yet emergent, and paced yet has flexible approaches', thus fitting with grounded theory well (Charmaz, 2006: 28). Its in-depth nature fostered eliciting the views of both the midwife and women participants' subjective world and ensured the rich and dense data to be gathered (Charmaz, 2006). Compared with focus group discussion, the in-depth interview also has the advantage of building up rapport and ensuring privacy. Participants were more likely to share their personal experiences and perceptions that had the potential to explore the research inquiry in depth. Through engaging in dialogue with individual participants, I was more able to follow their responses, go beneath the surface of their descriptions, probe for more details, and facilitate their reflections; thus enabling collection of rich data. In addition, due to the busy shifts of the midwife participants and the postpartum status of the women participants, the individual interview was feasible for the present study.

With the purpose of maintaining rigour in qualitative data collection, I designed an interview guide with a few open-ended questions to help me focus on the research subject, whilst encouraging space for statements and narratives to emerge (Charmaz, 2006) (the initial interview guide see Appendix C). With the goal of facilitating the understanding of professional identity construction in midwives, questions were formulated to explore the background and demographics, experiences, incidents, opinions, and values of respondents. The interview guide was reviewed by my supervisors prior to implementation and checked with participants during interviews in order to ensure clarity and validity. As the research proceeded and the theoretical concepts emerged from the data, the interview guide was gradually modified and became more specific.

Charmaz (2006) indicates that the interview process has impact upon the data collected for grounded theory. Thus, to ensure the collection of pertinent and rich data, general interviewing principles and techniques were employed. Interviews began with general questions to make interviewees feel more comfortable and to

build up rapport between the researcher and the participant at the start. As a nursing teacher and through my personality, I have certain skills in communicating and making people relax and open to sharing their experiences. Such skills served me well in this research context. In addition, I felt my gender was strength in closing the social distance with female participants, in particular women participants, which was suggested by feminist researchers (Oakley, 1981). After initial conversation for ice-breaking, more specific questions and probing were followed by the 'threads' emerging from the participants' responses. During each interview, the interview guide was used flexibly, allowing me to explore issues as they emerged. In relation to the negotiation and interaction between the interviewer and the interviewee, Section 4.3.3.3 presented one detailed example of my reflection on one interview process.

All interviews with the midwives and women participants were conducted in Mandarin. The choice of date, time and location for interviews was proposed by the participants for their convenience. As midwife participants' work shifts were tight and sometimes unpredictable, they agreed to talk to me at their workplace after they finished day shift or during their lunch break. For women participants, due to their postpartum status, the interviews with the women were all conducted at their homes. Written consent was obtained at the beginning of each interview. All interviews were digitally recorded and each lasted an average of one hour.

While there has been a debate around recording of interviews (Stern and Covan, 2001), in my study the use of audio recording during interview provided benefits of both a detailed and accurate account of the interview for further examination. It can help to reduce the risk that the researcher's sub-consciousness leads to memorising the data based on preconceptions (Charmaz, 2006). In the meanwhile, some disadvantages were attended to, such as participants may become hesitant to disclose information when noticing the presence of the digital recorder. To reduce the potential deficiencies, participants were informed in the consent process that the interviews were recorded and were reassured of the confidential use of the

data. Also, I selected a small recording tool to limit its possible intrusiveness upon the participants.

Apart from the interviews, three work journals were voluntarily provided by the midwife participants (Emma, Juliet and Jenny). These written documents deepened the insights into the midwives' understandings and interpretations of their professional identity construction through their work stories and their reflections of these stories. These written narratives served as a complement to the main data collection method (in-depth, face-to face interview).

4.4.5 Data Management

Twenty interviews were all transcribed verbatim by myself. Transcribing on my own allowed me to interact closely with the data and to identify the underlying meanings from the participants' words. The recording of each interview was transcribed into an electronic format to enable clear examination and analysis of the data. Any potential identifying information in terms of the individual or organisations was removed or an alternative description was used to ensure participants' anonymity. Computer package NVivo 8 was used to manage the data, organise my analytical work and store files and documents related to the study. This software provided me with a useful tool to manage my data under GT approach by transcribing the interviews, coding the data, making constant comparisons between the codes, identifying the categories, modelling the relationships among categories and recording the research memos.

4.4.6 Translation Issues

As research quality is reliant on the researcher's theoretical sensitivity to the meaning behind the data, attention needs to be drawn to whether data analysis should be based on the original Chinese version or the English translation. It has been a concern that due to some issues in translation, such as grammar, wording,

terms and meaning, it is hardly possible to find a perfect match between the meanings in different languages (Capitolo et al., 2001, Lin, 2008). Considering these translation issues and the need to develop theory grounded in the data for this study, the raw data were analysed and coded in Chinese by myself at the open coding stage. The codes and the quotations of the respective codes developed from open coding were then translated into English, while the raw data still remained in Chinese for further check-up and comparison. The following coding processes (focused coding, axial coding and selective coding) were undertaken on the basis of the translated open codes, whilst I constantly went back to check up the raw data and compare them with the developed codes during these stages. The coding process is detailed later in section (4.4.7.1). In addition, for the consistency of the translation I was the only translator and undertook all the translations for this study. To ensure the legitimacy, accuracy and readability of the translation, a bilingual colleague was consulted during translation and also helped me to check a selection of the translations independently.

The translated excerpts and the developed codes (in English) were shared with the supervisors to facilitate the analysis process and supervision. The potential limitation was that the open coding process was based on Chinese versions of the transcriptions. Therefore, my analytical thinking around the raw data at this stage was hard to share with my supervisors, who are not Chinese speakers. In order to ensure an independent audit trail, I translated the initial five interviews into English and discussed with my supervisors how I conducted the line-by-line coding at this stage.

4.4.7 Data Analysis

Analytical procedure started with transcription and review of the first interview. Data collection and analysis were undertaken simultaneously (Glaser and Strauss, 1967) as described in the sampling Section 4.4.3. Constant comparison and memo writing were conducted throughout the study to assist the analysis process.

In keeping with the GT approach that I adopted in carrying out this study, the narratives in the three work journals provided by the midwife participants were analysed through the same coding procedure as the interview transcripts were processed (the coding procedure is illustrated in the following text). This method of analysing narratives was termed by Polkinghorne (1995: 13) as 'analysis of narratives'; using narratives as data and 'seeking to locate common themes or conceptual manifestations among the data'.

4.4.7.1 Coding

Coding formulates the bones of the analysis whereby data are conceptualised, refined and further sorted to assemble the 'skeleton' of the final theory (Strauss and Corbin, 1998: 281). There have been different opinions regarding coding process among GT approaches. The major debate is the choice of the coding procedures between Glaser's (1978) and Charmaz's (2006) two-step approaches (the substantive and theoretical coding or the initial and focused coding) or Strauss and Corbin's (1990, 1998) three-step approach (open, axial and selective coding).

Both of the Glaser's and Charmaz's two-step approaches are more open and flexible which suit the researchers who 'prefer simple, flexible guidelines and can tolerate ambiguity' (Charmaz, 2006: 61). Conversely, Strauss and Corbin's coding techniques are more pragmatic that generally attract the novice GT researchers by its more explicit and structured guidelines for data analysis (Charmaz, 2006). In terms of Strauss and Corbin's coding schema, some theoretical debates asserted that it may lead to the data analysis in the way that "the technical tail is wagging the theoretical dog" (Melia 1996: 376). However, with the development of GT, Strauss and Corbin (1998) laid more emphasis in their statement of the coding procedure on that the coding techniques were needed to be carried out with a certain degree of flexibility and creativity. In so doing, they suggested the GT researchers to choose and tailor the coding techniques in order to fit with 'their abilities and the realities of their studies' (Strauss and Corbin, 1998: 295).

For this study, Strauss and Corbin's (1998) more explicit coding procedure (open coding, axial coding and selective coding) was not considered restrictive but rather pragmatic to guide a novice GT researcher to conduct the data analysis. Rather than adhering to this coding procedure rigidly, I used it as a guideline that was open to be adapted to the research context. Given the cyclical nature of GT approach, while the coding processes are presented sequentially in the following text, these occurred iteratively in practice.

- ***Open Coding***

Open coding was the initial stage, at which the data was broken down into units, was labelled, conceptualised and compared with similarities and differences (Strauss and Corbin, 1998). The choice of conducting the transcription and translation by myself entailed my immersion in the data and prompted me to identify the recurring themes, similarities and differences within and across the interviews. Such immersion also enabled me to discern the gaps in the data, to distil the data and then guided me to collect the needed data in the following stages.

The size of the data unit for coding can vary from word to word, line by line to incident to incident, depending on the nature of the data (Charmaz, 2006). Line-by-line coding is generally recommended by grounded theorists for the detailed data of 'fundamental empirical problems or processes' (Charmaz, 2006: 50). This type of coding helped me to see the nuances in the data, but also to remain critical about it by keeping myself from being so immersed in the participants' standpoints. In relation to identity study, narrating life story to oneself or others plays a significant role in constructing self-meanings, thus I argue that coding needs to embrace the segments of participants' accounts as well as the whole picture (the narratives). Therefore, the general approach to coding was guided by line by line coding whilst the incident by incident coding was also included, particularly in the analysis of the three work journals.

As explained in Section (4.4.6), open coding was undertaken in Chinese in order to preserve the original meaning. These open codes were then translated into English for further analysis. One example of the coded interview transcripts is provided in Appendix D (in order to facilitate the reader to understand, both the Chinese and English versions of the transcription and codes are presented).

The stage of open coding involves the development of categories through a process of classifying and categorising concepts. By this means, 'events, happenings, objects, and actions/interactions' that shared similar characteristics and meanings in nature were merged into the more abstract concepts named as 'categories' (Strauss and Corbin, 1998: 102). Categories are conceptually defined in keeping with their content and scope in order to explore a process or a pattern (Strauss and Corbin, 1998). Appendix E uses the conceptual category 'reducing the risk' as an example to demonstrate the development of a category in the coding process from the raw data, open codes to the category. My analytical thinking about the generation of the category ('risk concerns') is demonstrated in Memo Appendix F. During the classification and categorisation, the open codes were grouped into fourteen conceptual categories (see Appendix G).

- ***Axial Coding***

Once the important categories were identified, the next step was to develop them by defining their properties ('the general or specific characteristics or attributes of a category') and dimensions ('the location of a property along a continuum or range') (Strauss and Corbin, 1998: 117). This stage is termed by Strauss and Corbin (1998) as 'axial coding'; whereby the fractured data in the previous coding stage were reconstructed in order to link the categories together along the lines of their properties and dimensions. Corbin and Strauss (2008) acknowledged that 'categorisation' (at the open coding stage) and 'axial coding' were separated only for explanatory purpose. In practice, the two processes often merge together, as happened to this study: axial coding began when certain categories developed from

the analysis of the initial five interviews, which enabled the development of the subsequent categories and the relationships around 'the axis of a category' (Strauss and Corbin, 1998: 125).

To facilitate axial coding, Strauss and Corbin (1998) developed a 'coding paradigm' to ask 'questions about the conditions, actions/interactions, and consequences of categories, thus making links between the ideas being conceptualized from the data' (Mills et al., 2006: 5). The use of coding paradigm has been one major contentious issue central to GT analysis. Glaser (1978) and Charmaz (2006) both asserted that the paradigm worked as a priori framework that contradicted the original idea of GT of developing theory grounded in the data. However, Charmaz (2006: 61) also acknowledged that the framework may 'extend' the vision of the researcher, depending on the 'subject matter'. Bearing such contention in mind, Strauss and Corbin (1998: 129) emphasised that analysts should focus on understanding 'the nature and types of relationships' amongst categories, rather than rigidifying the coding paradigm and letting it preventing them from 'capturing the dynamic flow of events and the complex nature of relationships'. For this study, I agree with Glaser and Charmaz' assertion, rather than taking the coding paradigm as a strict template, I used it flexibly according to what emerged analytically. During axial coding, fourteen conceptual categories were grouped into six principle categories. Appendix G provides a summary of the coding process, showing a link from the development of the open codes to the conceptual categories, and to the refined categories at axial coding.

Through the analytical process, I found the development of the principle categories has extended the initial examination of identity construction to its contextual nature. In order to represent the structure and process of the midwives' professional identity construction and to link the six principle categories, the 'coding paradigm' was adapted to the present study to organise these categories under broader groups in terms of 'contextual condition', 'causal condition', 'action/interaction strategies' and 'consequences' (Strauss and Corbin, 1998: 123).

According to the paradigm framework, the 'contextual condition' is defined as 'patterns or sets of conditions' within which the 'action/interaction strategies' of the study subjects take place (Strauss and Corbin, 1998: 132). The '*institutional position*' category in this study elaborates midwifery status at the institutional level, which constitutes the 'contextual condition' in which the midwives' professional identity was constructed.

The 'causal condition', in the paradigm framework, refers to "sets of events or happenings that influence phenomena" (Strauss and Corbin, 1998: 131). The categories '*organisational management*' and '*professional discourse*' interplay with each other to demonstrate the contradictory ideologies underlying midwifery practice in hospital settings, which form the 'causal conditions' determining the midwives' professional identity construction in the hospital settings.

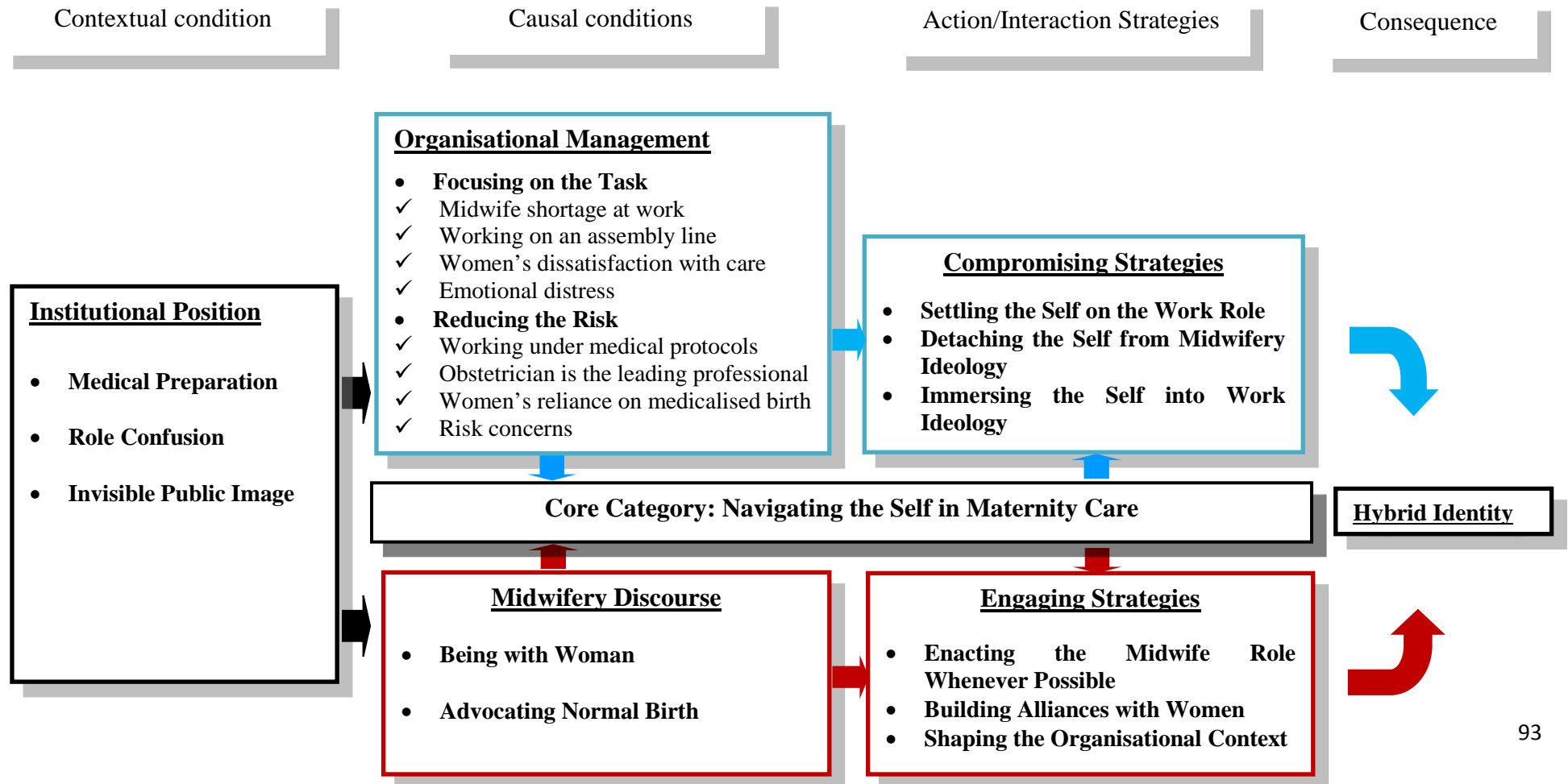
'Action/interaction strategies' are defined in the paradigm framework as "purposeful or deliberate acts that are taken to resolve a problem and in so doing shape the phenomenon in some way" (Strauss and Corbin, 1998: 133). The categories '*compromising strategies*' and '*engaging strategies*' represent the 'action/interaction strategies', which midwife participants employed to construct their individual professional identity in hospital settings.

The 'consequences' resulted from the 'action/interaction strategies', "some of which might be intended and others not" (Strauss and Corbin, 1998: 134). In this study, resulting from the 'compromising strategies' and 'engaging strategies' is the consequence, '*hybrid identity*', which represented the dynamic construction of individual midwives' professional identity, navigating between the internal definition ('obstetric nurse') and the external definition ('professional midwife') of the midwife.

Six principle categories (bold and underlined text), thirteen sub-categories (bold text) and several concepts were constructed and interrelated by using the paradigm

framework presented in Figure 2. The relationships between these categories and sub-categories are marked by the arrows. Two different colours were used to demonstrate two competing definitions of midwife derived from the maternity care institution (blue) and the midwifery profession (red), and the subsequent action/interaction strategies that midwives adopted to construct their professional identity in practice. The use of this paradigm framework in the axial coding process enabled the principle categories to be organised in a logical way and the relationships among these categories to be presented clearly.

Figure 2: Relationships of the Core Category and Categories by Using the 'Paradigm' Framework (Strauss and Corbin, 1998: 123)



- ***Selective Coding***

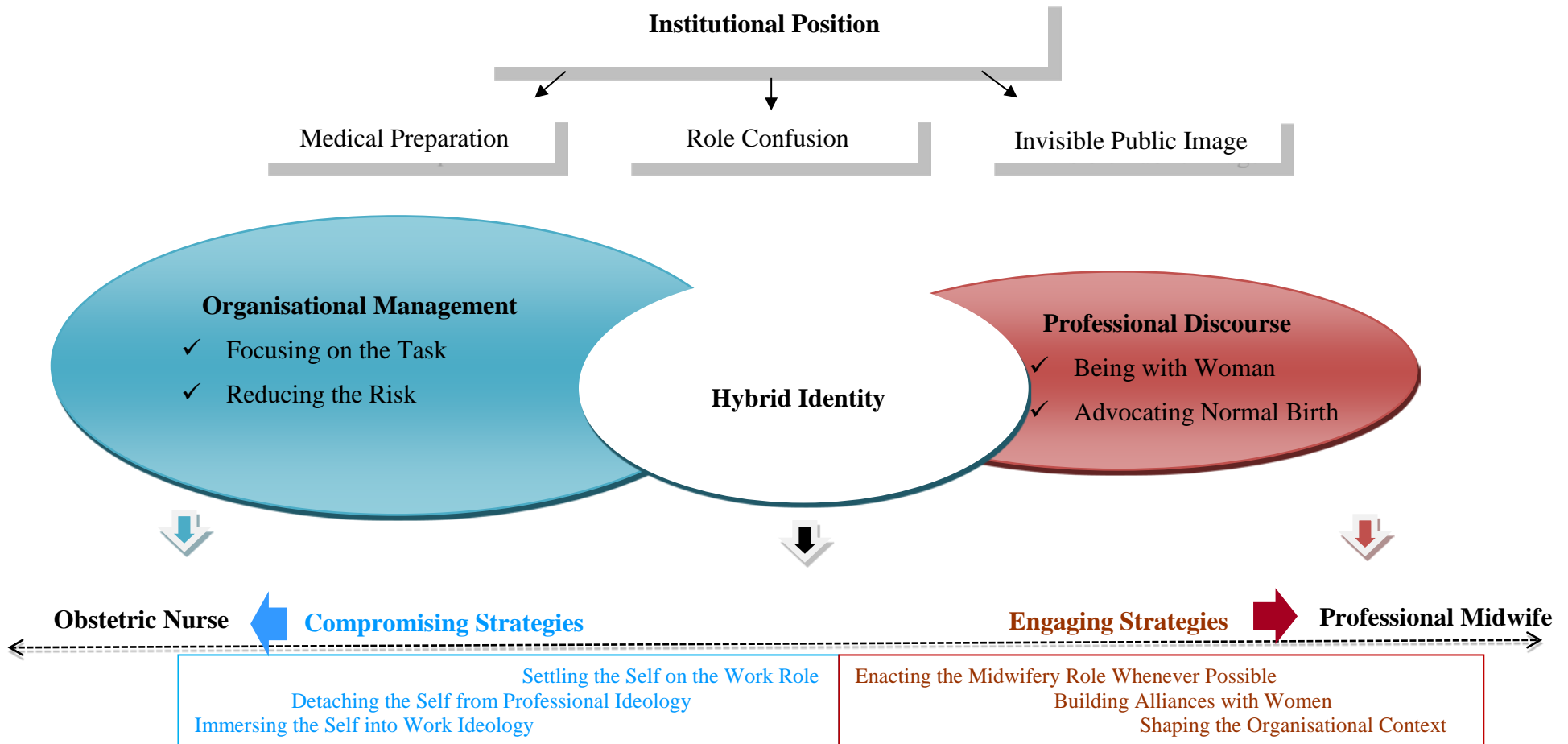
Selective coding is the final step of the coding process. This process involves 'integrating and refining categories', as well as identifying the 'central category' whereby the theory is constructed (Strauss and Corbin, 1998: 143). Strauss and Corbin's (1998) acknowledgement of the role of the researcher in theory construction is evident in this coding process by selecting a category that has the ability to integrate all other categories to develop an explanatory story.

In this final stage, the core category of this study was identified as 'navigating the self in maternity care', which was central to all other categories and linked them together. The core category, six principle categories and thirteen sub-categories have been presented in Figure 2. To explain how hospital-based midwives tried to fit into the maternity care system while not losing their professional sense of self in the process of constructing a professional identity, the core category was further interpreted and presented by diagramming (Figure 3), showing that the midwife was navigating on an identity continuum with one end being 'obstetric nurse', to 'professional midwife' at the other.

In this study, during the development of each category some experiences and perceptions from certain participants seemed to provide 'deviant cases'. The examples as such can be seen in Emma's case that was explained in section 4.4.3 and detailed in section 5.2.1; the midwife participants' different interpretations of 'advocating normal birth' (detailed in section 6.3.2); and some midwives who seemed to be immersed into the work ideology without noticing the identity dissonance (detailed in section 7.2.3). However, the intention of seeking informants whose experiences deviated from the theoretical categories has facilitated the development of a substantial theoretical model that accounts for and fits with all the grounded data. Therefore, the theoretical model for this study was developed and abstracted to be an identity continuum. All of the midwife participants were able to identify their experiences and perceptions within the model and locate themselves

somewhere along the identity continuum. The explanation presented here is to help the reader appreciate the analytical process. The subsequent findings chapters will evidence in detail how the findings relate to the development and refinement of the theoretical model.

Figure 3: Theoretical Model - 'Navigating the Self in Maternity Care'



4.4.7.2 Constant Comparison

Constant comparison is a fundamental technique in GT for the researcher to systematically sort large volumes of raw data. Throughout the coding process, data were continually examined and compared to each other to identify similarities and differences in order to form meanings and develop theoretical concepts (Strauss and Corbin, 1998). This technique entailed an iterative process of analysis for this study, which compared data at each analytical (coding) level and across different levels until the theoretical model was developed.

4.4.7.3 Memo Writing

Memo writing worked throughout the analysis process. It is an ongoing dialogue between the researcher and the data to record the researcher's understandings of and insights into the data, refining the emerging categories and primary theory (Charmaz, 2006). This technique allowed the researcher to analyse, question and clarify meanings generated from the accounts of participants and the analytical interpretations of the researcher (Charmaz, 2006). Throughout the study, memo writing enabled me to record my analytical thinking, to reflect and refine the research procedure and to gain deeper insights into the participants' experiences, perceptions and behaviours in relation to the research inquiry, and the context within which the theoretical model was developed. Considering Charmaz's (2006) suggestion, the research memos were recorded more freely in order to grasp the momentary thoughts of the codes, the emergent categories, and the relationships between categories as the study progressed. An example of a memo is presented in Appendix F.

4.5 Ethical Considerations

This study undertook two phases in gaining ethical clearance. The primary ethical approval was obtained from the Ethical Committee of the School of Health in Social Science at the

University of Edinburgh where I am studying for a doctorate and the Academic Committee in Hangzhou Normal University of China where I work (see Appendix H). Access to the potential participants was achieved by consent from relevant gatekeepers in the hospitals and community health centre, and from the participants themselves (midwives and women) (for information sheets to the relevant gatekeepers and participants see Appendix I; and consent forms see Appendix J). The ethical considerations for this study drew on the principles of the Research Ethics Framework stipulated by the Research Ethical Committee of the School of Health in Social Science at the University of Edinburgh (2008). With reference to this framework, ethical recruitment, protection of participants from harm and respect for anonymity and confidentiality are addressed in the following text.

4.5.1 Ethical Recruitment

A considered recruitment and balanced relationship between the researcher and the participants can 'encourage disclosure, trust, and awareness of potential ethical issues' (Orb et al., 2001: 94). The potential ethical issues in terms of the recruitment of the midwife and women participants have been acknowledged and addressed in Section (4.4.2). Careful thoughts and strategies in terms of the relationship between the researcher and the participants during the research process have also been considered in Section (4.4.2) and Section (4.4.4).

4.5.2 Informed Consent

The potential participants were contacted by myself through a phone call to gain their consent to participate in the study. I explained the purpose of the study during initial contact. The interview date, time and venue were decided when they agreed to participate. At the beginning of each interview, an Information Sheet (see Appendix I) was given to the participant, with details of the aim, design of the study and the likely presentation and publication of the findings. Contact information for myself and my supervisors was also

provided on the Information Sheet to help the participants acquire further information when they needed.

Participants were fully informed that their participation was on a voluntary basis. They were assured that they would not suffer any detriment if they chose not to participate and were able to withdraw from the study at any point if they wished. They understood that they could decline to answer any questions or refuse to be audio recorded during the interview. They were also informed that a follow up interview or contact could be held for clarification of some points raised in the interview and member checking. When they agreed to take part in the study, written consent forms were signed by the participants and researcher before the interview commenced.

4.5.3 Anonymity and Confidentiality

The issues of anonymity and confidentiality were addressed in a variety of ways throughout this study. To maintain confidentiality, audio recorded interviews were transcribed and translated by myself. All data were stored securely in the office locker. Electronic files were kept in my password-protected laptop to ensure the security of the collected data. The raw data can only be accessed by myself and my academic supervisors. The data will be retained securely for seven years upon the completion of the study for university requirements and then will be properly destroyed.

The research setting and participants (including the city, the hospitals and health-care centre) were all given pseudonyms or general descriptions. Anonymity may not guarantee participants complete confidentiality, as there is a potential risk that some characteristics of the study context or participants of importance to the study might disclose their identity, possibly through specialist services in work settings or the participants' posts. For this reason, an assurance was given to participants regarding my treatment of all data. I assigned a pseudonym to the city (Eastern City) where I conducted this study and avoided mentioning

specific information involving the participants' workplace or their background by using alternative descriptions in the presentation of the study findings and in any publications related to the study. When some identifiable characteristics were too important for the developed theory to be disguised, I contacted relevant participants for their approval.

4.6 Quality of the Study

The issues of quality in qualitative research have been argued and debated till now in an attempt to reach a consensus on universal quality criteria e.g. (Morse et al., 2002). However, such an attempt is unlikely to be achieved because there is no unified qualitative research paradigm which can embrace and guide a whole range of qualitative studies (Rolfe, 2006). Bearing in mind that 'philosophical underpinnings or theoretical orientations and special purposes for qualitative inquiry will generate different criteria for judging quality and credibility' (Quinn, 2002: 542), a diversity of quality criteria are warranted. In light of the methodology underpinning this research, four criteria - 'credibility, originality, resonance and usefulness' - proposed by Charmaz (2006: 182) were used to evaluate the 'interpretive sufficiency' of the developed theoretical model for this study.

4.6.1 Credibility

Credibility is the criterion to evaluate whether the findings of qualitative research represent a credible and believable interpretation of the data drawn from the perspectives of the participants in the research (Charmaz, 2006). It entails both the quality of the research process and confirmation of the research findings from the study subjects (Bryman, 2008). In this study credibility was addressed in four ways.

Firstly, to allow the reader to evaluate the credibility of the study, research methods and processes were discussed in a detailed manner early in this chapter. By means of constant

comparison, the credibility of emergent meanings and concepts was constantly checked through a coding process, which was fully illustrated in Section (4.4.7).

Secondly, theoretical sampling methods enhanced the credibility of the study by its ability of self-correcting (Charmaz, 2002), which identifies gaps from the developed categories, follows the theoretical hints for further sampling and finally saturates these categories (Strauss and Corbin, 1998). For example, in light of the developed categories 'invisible public image', 'women's dissatisfaction with care' and 'women's reliance on medicalised birth', the study recruited women participants, which has added an additional perspective on the midwifery experience and the context where midwifery care took place. This different data source also provided richer and more comprehensive data to achieve deeper insight into the contextual factors that influence midwives' professional identity construction. In addition, the study also included three work journals from midwife participants. The work narratives and midwives' reflections on these narratives provided deep insight into the midwives' interpretations of their professional identity construction. The written documents together with the main data collection method (in-depth interviews) enabled a more complete understanding of the subject under study. Using more than one data resource or method in the study is referred to as triangulation, which helps to enhance the credibility of qualitative research (Bryman, 2008).

Thirdly, respondent validation (Bryman, 2008) and independent audit were used to support the trustworthiness of the data. Respondent validation was conducted in different ways and at different stages of the study. During the data analysis, some transcriptions of the interviews were sent back to the midwife participants for feedback and further clarification. When the theoretical model was developed, a summary of the findings was sent back to three midwife participants to gain their feedback about whether the developed theoretical model had reflected the reality they experienced. Additionally, as an independent audit trail, the analysis was discussed with my academic supervisors throughout the research. These

discussions added great insights and offered different views to the development of the theoretical categories and final theoretical model.

Fourthly, Strauss and Corbin (1998) have recommended that the GT researcher is expected to possess qualities including 'appropriateness, credibility, intuitiveness, receptivity and sensitivity'. As discussed in Section 4.3.3, my position as an obstetric nursing educator and the knowledge gained from my experiences of working and research in maternity care were found to increase these qualities for me as a researcher to undertake GT. In the meantime, in order to retain openness to the data, research memos were used to help me reflect on my background assumptions and their interactions with the data.

4.6.2 Originality

Originality in Charmaz's (2006) criteria refers to an assessment of the originality in research findings, including the new insights of the categories, new conceptual frameworks, and the social and theoretical significance of the research. Originality in this study was evaluated by a return to the literature to compare the research findings with the existing knowledge in the field at the latter stage of the research, which is presented in the discussions within each findings chapter from Chapters Five to Seven and in the conclusive discussion chapter (Chapter Eight).

4.6.3 Resonance

The use of resonance here is similar to conformability; that is to measure how well the developed theoretical model can 'speak specifically for the population from which it was derived and to apply back to them' (Strauss and Corbin, 1998: 267). The resonance of the developed theoretical model was tested by bringing the raw data into the model and by a memberchecking or respondent validation process (Bryman, 2008). In the process of member checking, a summary of the final findings was sent back to three midwife participants from whose experiences the theoretical model was developed. All three

participants acknowledged the findings as clear representations of the reality they experienced in their everyday practice. In addition, the resonance of the research findings has also been tested by being presented to a wider audience. This was done via formal presentations at several conferences, where midwife audiences from China and other countries found more or less a 'fit' of the theoretical model to what they had experienced within their own settings.

4.6.4 Usefulness

Usefulness is an evaluation of the practical significance of the research findings and the direction for further studies (Charmaz, 2006). To evaluate the usefulness of the final findings, the practical significance of the research and the recommendations for further studies are addressed in Chapter Nine.

4.7 Limitations of the Study

To secure research quality, the study has been designed and processed in careful consideration of research inquiry under agreement from and discussion with my academic supervisors. However, considering the time and resource constraints for a doctoral project, the limitations of the study need to be recognised.

First of all, there have been critiques of qualitative research in terms of generalisation, particularly from the quantitative researchers' perspectives. As qualitative research focuses on a small number of subjects located in a certain setting, it is argued that the findings cannot be generalised to other settings (Bryman, 2008). However, qualitative researchers argued that findings of qualitative study aim to 'generalise to theory' rather than generalise to a wide context or populations (Bryman, 2008: 391). Therefore, 'it is the quality of the theoretical inferences that are made out of qualitative data that is crucial to the assessment of generalisation' (Bryman, 2008: 392). Likewise, as the current study was conducted in a

specific geographical area of China, findings could not be applied to the wider context without any problems. However, the theoretical model developed from this particular area does have the potential to make theoretical inferences in similar settings, and to be extended and developed in other areas in further studies.

Secondly, in qualitative research the researcher is the main research instrument of data collection and analysis, thus it has been criticised as 'too subjective' (Bryman, 2008: 391). The criticism concerns that qualitative research often initiates 'in a relatively open-ended way' and gradually narrows down the research focus without sufficient clues to the audiences (Bryman, 2008: 391). However, for grounded theory approach, the theoretical sampling method and the relatively structured coding procedure can ensure that the research orientation is directed by the theoretical thread grounded in the participants' perspectives. Nonetheless, considering I was the only researcher to conduct this study, researcher bias could be seen as an underlying disadvantage. In order to minimise this potential limitation, various forms of triangulation have been incorporated into this study (Bryman, 2008) via bringing in the different data resources and different data collection methods; comparing findings with existing literature, using respondent validation and independent audit, as detailed in Section (4.6).

Thirdly, in the research setting there was no registration data of midwives when the study began. Also, because of the midwives' busy work schedule, I couldn't attract any volunteers through distributing information sheets to hospitals. The recruitment of the midwife participants was thus through a convenient method of sampling the participants by virtue of its availability. The convenience sampling has been contended as not being able to generalise the research findings (Bryman, 2008). This is acknowledged as a potential limitation of the study. However, as a qualitative research aims at an in-depth analysis, the attentions of representativeness in this study were not paid as importance as quantitative research does (Bryman, 2008). Additionally, the recruitment procedure might also have impacts upon the data in that some of the midwife participants, whom I knew before, may

have felt obligated to participate in the study, others may have felt authoritative pressure from their midwife managers, whilst the women participants were only selected from the women who received midwifery care in hospitals (TGH and TMH) and are all relatively well educated. The remediation for such potential sampling bias was addressed in Section (4.4.2).

Fourthly, my educational background in nursing studies, vocational background as an obstetric nursing teacher as well as past experiences of working and doing research with midwives, all together brought some challenges to the current GT study. Nevertheless, my close relationship with the research area has also increased my awareness of the potential impacts that my assumptions could have on the research process. In this case, reflexivity throughout the research process was conducted as discussed in Section (4.3.3).

Fifthly, considering the practical issues, study data were gathered exclusively through individual interviews, with only three work journals provided by midwife participants. Including focus groups for an open debate of the various strategies midwives adopted to engage in midwifery discourse and more work journal resources of personal reflection on daily practice would enrich the depth of the data for future studies.

Sixthly, considering the limited time and resources, this study merely focused on hospital-based practising midwives who worked in urban and suburban areas. There was only one participant who had the experience of working in a rural area in the past. Future studies could be directed to the midwives who work in rural areas to gain deep understanding of how the current midwives in rural areas construct their professional identity, which can help to extend the theoretical model developed from this study. In addition, in the previous studies of midwifery and professional identity in other countries there are indications that the intra-group conflicts play a part in professional identity construction in midwives, particularly to the newly qualified midwives and student midwives (Foley, 2005, Hunter, 2005, Purkis, 2006). However, intra-group negotiation wasn't identified in the current study. Further study could focus on the newly qualified midwives and student midwives to further

explore if the intra-group relationship affects professional identity construction in Chinese midwives.

Finally, as the understanding of midwives' professional identity construction from midwives' own perspectives is the main purpose of this study, I only invited five women clients as a supplement to validate midwives' accounts. Future studies could extend the theoretical model developed here by increasing the number of women participants and specifically analysing the impacts of the woman-midwife relationship upon midwives' professional identity construction. Furthermore, in future studies, recruiting obstetricians and obstetric nurses could extend the dimension of knowledge by elaborating on the power dynamics and professional boundary management amongst these professionals and identifying the impact of such social interactions on the process of professional identity construction.

4.8 Summary

This chapter has explained the rationale of constructivist grounded theory (CGT) as the research methodology for this study. Following Charmaz's (2002, 2006) version of GT, based on the basic GT practice guideline, data collection and analysis were outlined including how 'navigating the self in maternity care' was identified as the core category. Reflexivity, ethical considerations, quality and limitations of the study have been considered to evidence the rigour of the research. In Chapters Five to Seven, according to the paradigm framework presented in Figure 2, the six principle categories that build up the developed theoretical model for this study are elaborated on with evidence from the raw data. Each category is also discussed in the subsequent chapters by drawing on the relevant literature.

CHAPTER FIVE: CONTEXTUAL CONDITION – MIDWIFERY STATUS AT THE INSTITUTIONAL LEVEL

5.1 Introduction to Findings and Discussions

In the following three chapters (Chapters Five to Seven) research findings and the analytical discussions are presented. The six principle categories and the constituent sub-categories of the developed theoretical model 'navigating the self in maternity care' (presented Figure 3 in Chapter Four) are systematically analysed; explaining how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. In accordance with the 'paradigm' framework (Strauss and Corbin, 1998: 123) demonstrated in Figure 2 (presented Chapter Four), the research findings are presented in the sequence of: contextual condition; causal conditions; action/interaction strategies; and the consequence. Direct quotes from the raw data are drawn on to demonstrate the logical links between the developed categories and the gathered data. With reference to the relevant literature, the findings are discussed at the end of each findings chapter.

Chapter Five examines midwifery status at the institutional level with the analysis of the principle category 'institutional position'. The sub-categories 'medical preparation', 'role confusion' and 'invisible public image' that the midwives' institutional nursing position has resulted in constitute the contextual condition, within which the professional identity construction in midwives took place. The examination of ideologies underlying midwifery practice at the organisational level is expounded with the analysis of two principle categories – 'organisational management' and 'professional discourse' – in Chapter Six. These two categories build upon each other to demonstrate the interplay between the external definition ('obstetric nurse' defined by the work organisation) and the internal definition ('professional midwife' defined by the profession) of the midwife in hospital settings, which results in identity dissonance of the midwives in practice. The coexistence and interplay of the 'organisational management' and the 'professional discourse' form the

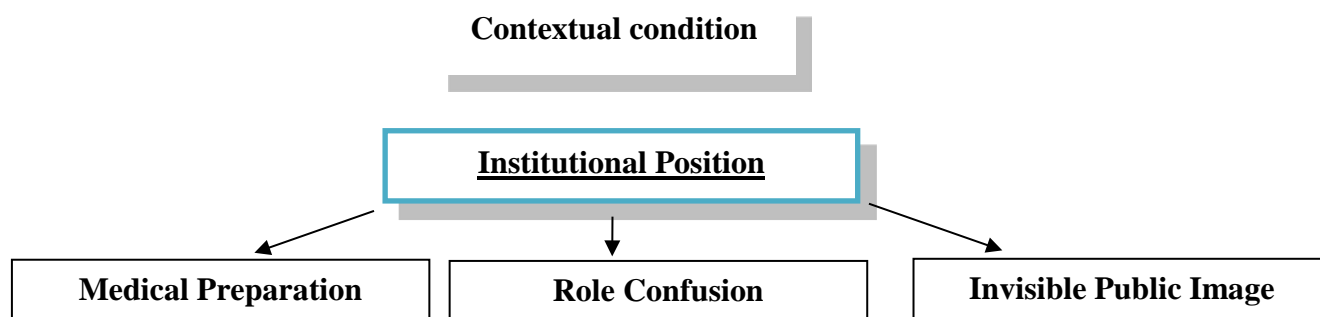
causal conditions that determine how individual midwives construct their professional identity in hospital settings. Chapter Seven examines the varying strategies that individual midwives employed to construct their professional identity in response to the identity dissonance in practice, and the consequence of these strategies. Two types of action/interaction strategy are identified to this end, which are conceptualised by two principle categories: 'compromising strategies' (concessions made to organisational management) and 'engaging strategies' (engagement in professional discourse). As the consequence of the action/interaction strategies, another principle category 'hybrid identity' emerged, in that the construction of the individual midwives' professional identity appeared to be navigating on an identity continuum with 'obstetric nurse' and 'professional midwife' at either end, being influenced by their experiences, opportunities for professional development, relationship with women and the definition of the situation. The interrelationships between the six principle categories were visually presented in Figure 3 in Chapter Four and will be elaborated on in the following three findings chapters.

5.2 Institutional Position

In this chapter, midwifery status at the institutional level is examined with regard to the principle category 'institutional position', which forms a contextual condition for the hospital-based midwives' professional identity construction. As aforementioned in the background of the research (Chapter Two), during the period of this study midwifery in China has been categorised as a subgroup of nursing, whilst the title 'midwife' (*zhù chǎn shì*) has not been officially used in maternity care system (Cheung, 2009, Harris et al., 2009). Midwife participants stated that their status in the current maternity care system was embodied in the title 'nurse', resulting in midwifery preparation being strongly attached to the medical model; they were experiencing a range of role confusion in relation to the obstetricians and nurses; and the image of the midwife has become invisible to the public. The medical preparation, role confusion and invisible public image appeared to be

fundamentally influencing the professional identity construction in midwives, which come together to constitute the contextual category ‘institutional position’ (see Figure 4).

Figure 4: Contextual Condition – Midwifery Status at the Institutional Level



5.2.1 Medical Preparation

Midwives identified the educational preparation in school and on-the-job learning as fundamental for developing their knowledge and skills for their work, and constructing their professional identity. Midwife participants – either the direct-entry midwives or nurse-midwives – indicated that they were trained with a strong medical background through learning in school and/or training at work which has influenced the construction of their professional identity.

The medical preparation was explicit in the accounts of the direct-entry midwives who were trained during the transitional period in the 1980s from being a ‘modern midwife’ to an ‘obstetric nurse’. Take Jenny for example:

Coping with the structural transition of midwifery at that time, the midwifery programme in our school emphasised the medical module. Our midwifery preparation was similar to the training of the obstetricians, so we had the chance to become obstetricians after further training. During clinical placement, we spent more than three months being mentored by the obstetricians and also assisted them with caesarean sections several times. (Midwife, Jenny (SH))

As introduced in Chapter Two, at the beginning of this transformation midwives were offered the choice of either being incorporated into a nursing group or becoming an obstetrician with further training (Chinese Ministry of Health and Ministry of Politics, 1979). The midwifery programme, as Jenny described, was like a quasi-obstetrician preparation in an attempt to offer the midwives opportunities to get an obstetrician qualification with further training. The experienced midwives who graduated from midwifery programmes during this period (Catherine, Emily, Linda, Ellen) echoed Jenny's statement, and indicated that they were trained with certain obstetric techniques (such as forceps, vacuum deliveries) and had performed these obstetric techniques before. As direct-entry midwife Ellen (TMH) commented: "In the past, we could do forceps, vacuums and even assisted breeches. Now, we can only assist obstetricians to perform such skills."

Other direct-entry midwives, who entered midwifery programmes when the profession has already been subsumed into nursing, also indicated that the theoretical knowledge they learned at school was fundamentally influenced by obstetrics.

When we were at school, we mainly learned the theoretical knowledge of midwifery, including physiological and pathological knowledge of childbearing, how to care for women during this period, how to care and assist at childbirth at the different stages, how to deliver a baby and to identify the abnormal ... our textbook is based on the textbook of gynaecology and obstetrics. (Direct-entry midwife, Daisy (TGH))

Moreover, the direct-entry midwives also identified the gap between their school education and clinical practice by commenting that the knowledge and practices they had learnt from midwifery programmes (technical secondary school or junior college) were inadequate to prepare them for practice. The on-the-job learning combined with apprenticeships and self-study approaches in their work settings were considered as the key pathway for the development of their professional identity, as Emma mentioned:

I feel the knowledge learned in midwifery programme was too theoretical and conceptual. Much of the knowledge cannot be applied

directly at work. We didn't have much opportunity to practise. The sense of what midwives do was more developed when I started to work. Each new qualified midwife will be mentored by an experienced midwife at the beginning of our career. We followed our mentor during her shift and learned the clinical knowledge and skills from her till we were ready to do it on our own. (Direct-entry midwife, Emma (TGH))

The role of on-the-job learning is of particular significance in socialising the nurse-midwives to midwifery practice, as they were purely prepared with midwifery knowledge and skills at their workplace (hospitals) after graduating from nursing programmes (technical secondary school, junior college or university education), as Mary explained:

When I was in nursing school, I had gained some theoretical knowledge of obstetrics and gynaecology, but didn't come across much midwifery. All these knowledge and skills were learned on the job. At the beginning, my clinical skills were taught by the experienced midwives and I tried to catch up with the theoretical knowledge by myself after work. (Nurse-midwife, Mary (TMH))

All midwife participants described that although their daily practices contained occasionally working in-patient antenatal care and postnatal care, midwifery skills in labour wards were weighted highly in their training, as Yvonne indicated:

Being a midwife, the skills in assisting labour and birth are the prerequisites, as quoted in our head midwife's words. It is quite true. Our training was focused on the skills of observing the stages of labour, baby delivery, episiotomy, suturing etc. It is the hardest part of becoming a midwife. (Nurse-midwife, Yvonne (TGH))

Midwives valued that the on-the-job learning, and more specifically the apprenticeship, have played a fundamental part in their professional socialisation at work. They suggested, at the point of becoming a midwife mastering the skills in labour wards was acknowledged as essential by the midwives, and these skills were imparted from the experienced to the novice ones. It implied that the technical skills were emphasised as a core competence of being a midwife during their on-the-job learning.

Midwife participants described that all their work settings were obstetric-led units, being operated under a medical model. Being trained in such a working context, midwives' on-the-job learning appeared to be medical-oriented. Such comments were particularly brought up by the midwives who had been trained and/or worked under a midwifery model, taking Emma for example:

I feel very lucky to have joined a midwife-led birth project at the beginning of my career. I was trained under a midwifery model. It was a really different experience compared to my previous experiences in the traditional model [the obstetric-led model] ... The traditional one is more risk-focused, while the midwifery model emphasises continuous and woman-centred care. Midwives play a key role rather than obstetricians. I felt the meaningfulness of my work. (Direct-entry midwife, Emma (TGH))

In this study, one work setting (TGH) has implemented a midwifery model in one labour room of the unit, though the entire maternity unit was still obstetric-led. Emma was the only midwife participant who was trained under this midwifery model at the beginning of her career. When talking about the process of her professional socialisation, Emma valued the 'continuous, woman-centred care' as a foundational concept of midwives' professional identity rather than the medical knowledge and techniques. Emma's words suggest that the knowledge, skills and principles they've learned from their working context had significant influence upon the construction of their professional identity. As the majority of the midwife participants were prepared in the context where the medical model was dominant, their professional identity construction was inevitably influenced by such an ideology at the workplace (see category 'organisational management' in Chapter Six).

5.2.2 Role Confusion

When midwives described their professional identity, they commented that their institutional nursing position has redefined the role of the midwife. They often expressed a

sense of role confusion in relation to the obstetricians and the nurses in the current maternity care system.

The experienced direct-entry midwives explained that after being grouped into the nursing profession, they have lost their ever-broader practice sphere to the obstetricians, such as outpatient clinic practice, as nurses are not entitled to do this:

In the past, there was a midwifery outpatient clinic for antenatal examination in this hospital. When the woman was detected to be abnormal, we referred her to obstetricians. However, now as a nurse, we are not qualified to see patients in the outpatient clinic. It was terminated. If we could still do this, there is no need to make other efforts to publicise our profession. What we have done is the most effective way to get public recognition. (Direct-entry midwife, Emily (TMH))

When recalling the ever-broader scope of practices, these midwives argued that because of their current nursing position the practices that they could perform in the past have been legitimately taken over by obstetricians. They felt that they had lost part of their professional domain and autonomy as a professional midwife. While losing the responsibilities of seeing women in the outpatient clinic, midwives found they also lost leverage to advocate for their profession to the public. The invisibility of the midwives' image to the public is discussed in Section (5.2.3).

Likewise, the experienced direct-entry midwives (e.g. Ellen, Emily, Jenny) also claimed that certain obstetric techniques were eliminated from their scope of practice, since being incorporated into nursing groups. Handing over these skills to the obstetrician frustrated the midwives as they considered these techniques as significant components of being a midwife:

In the past, we could do forceps, vacuums and even assisted breeches. Now, we can only assist obstetricians to perform such skills. We lost them. It upset me. Obstetricians' scope of practices is expanding whilst our responsibilities are diminishing.' (Direct-entry midwife, Ellen (TMH))

In respect of the past experiences in midwifery care, the direct-entry midwife Jenny is another case. After graduating from a midwifery programme in 1994, she was assigned to work in a township healthcare centre, where she was required to perform some of the obstetrician's roles. At the time of this study, Jenny has been promoted to be a midwife manager and transferred to a secondary hospital, where her practices became similar to the other hospital-based midwives. Compared to her previous extended practices, the recent experiences of working in the hospital with limited autonomy in practice were viewed as devaluing her professional sense of the self:

I know my previous scope of practices was broader and made me feel quite stressed. However, the problem is when I return to the hospital I feel I am working purely as a nurse with little autonomy here. (Direct-entry midwife, Jenny (SH))

The above extracts indicate that there was an extended role definition of a previous Chinese midwife (such as performing forceps, vacuum deliveries or taking on some roles of the obstetrician) in comparison to the commonly defined midwife by the ICM (2011a) and in many other countries. For example, in the UK, instrumental deliveries have been the practice of obstetricians and midwives almost invariably conduct normal deliveries (Royal College of Anaesthetists et al., 2007). Regardless of this, for the participating midwives in this study, handing over their previous practice domain to the obstetricians and enacting merely the role of an obstetric nurse has, in effect, confused them about the role of the midwife and undermined their sense of professional identity.

Apart from comparison with obstetricians, midwives also indicated their role confusion in relation to the nurses. Although in some western countries midwives have relatively clear roles for their practice, still the blurred boundary between the midwives and the obstetric nurses is problematic, particularly for the hospital-based midwives e.g. (Hazle, 1985). In China the situation is that midwifery has become a sub-branch of nursing under the current healthcare policy, and there is no statutory body or professional organisation only for midwives as a result. Midwives are regulated under the general Nurses Act (Wen, 2008),

which defines what role they perform and how they perform it, inevitably blurring the boundary between the role of the midwife and the nurse, as Daisy commented:

There is no independent statutory body or professional body for us. Our practice is regulated under the management of nursing profession. Our practices are mixed up with the roles of nurses. (Direct-entry midwife, Daisy (TGH))

As midwife participants described, the role of a midwife varies in different hospital settings. Midwives in this study primarily worked in labour wards and managed normal deliveries. Their daily works include: preparation and maintenance of the labour wards, monitoring labouring women, attending births, and assisting early breastfeeding. They also recorded medical case notes and assisted obstetricians in treating women with complications. They provided inpatient antenatal care and postnatal care occasionally (Juliet, TMH; Ellen, TGH). In some secondary hospitals, they also worked in the gynaecology wards (Jessica, SH; Jenny, SH); while others only worked within the labour wards (Maya, SH).

In the current maternity care system, this unclearly defined professional role has unavoidably affected the construction of a professional identity in midwives. Together with the condition that midwifery practice is under the management of nursing and guided by the protocols for nurses, midwives noted that their midwives' role has been downgraded to be largely that of an obstetric nurse:

Our protocol is based on the 'nursing management and clinical nursing technique standards' released by provincial health administration and the 'obstetric nursing routine' used in each hospital. Actually, in the hospital our work is mainly what nurses do. (Direct-entry midwife, Jenny (SH))

Not only does the sense of role confusion manifest in the diverse midwifery scope of practice, it is also reflected in the way that the administration evaluated the competence of the midwives. As one midwife in a general hospital mentioned, midwives were supervised

by the nursing managers who basically lacked acknowledgement of the role of the midwife, thus they were often evaluated on the criteria for the general nurses:

Nursing managers evaluate our professional competence according to the nursing techniques standards. They thought we were not as competent in those techniques as the nurses are. You know, midwifery has its own specialisms, but they just emphasise those nursing techniques. (Direct-entry midwife, Linda (TGH))

This statement was echoed by the midwives working in the general hospitals, though it was viewed to a varying degree by the individual. It reflects that midwives' institutional nursing position has not only masked their expertise, and caused role confusion to the midwives themselves, but has also resulted in a lack of value and acknowledgment of their professional role by others. More importantly, as the nursing position has influenced managerial expectations of the midwives and subsequently the opportunities for them to assume their professional role in practice, midwives are liable to be assimilated into the nursing role.

As the result of the redefined role of the midwife in the current maternity care system, midwives' professional autonomy is undermined under the obstetricians' authority, whilst their professional role is at risk of being undervalued by nursing administration; thus the construction of their professional identity is unavoidably affected (see category 'organisational management' in Chapter Six).

5.2.3 Invisible Public Image

In a similar vein, midwives unanimously commented that their nursing position also affected their public image, and more important, the public recognition of their function as a midwife.

Midwives stated that their midwife identity has been invisible to the public:

Generally speaking, in the public, most people have no idea who is the midwife and what a midwife does. I feel they know nothing about us. (Direct-entry midwife, Emily (TMH))

Midwives felt frustrated as their professional title 'midwife' has become unknown amongst the public and they were identified with general nurses. Such misunderstanding of the professional title was identified by midwives as the source of their invisibility to the public. More notably, accompanied with the confused title is that their function as a midwife is less acknowledged and undervalued by their clients:

Once a husband told me, 'I was so surprised that the nurse didn't call the obstetrician, she delivered my baby on her own'. (Direct-entry Midwife Linda (TGH))

Reflected in the husband's words is that the public viewed midwives as identical to the general nurses, who were not qualified to attend childbirth alone. Given the invisible public image of the midwives and the subsequent misunderstanding of their professional role, obstetricians were undoubtedly granted an expert position in childbirth management including baby delivery. Such perceptions were also evident in the women participants' accounts. Two of the women participants were even not aware of having been cared for by midwives:

To be honest, I have no idea who cared for me during my childbirth. I thought they were obstetric nurses. Oh, there was one who helped me deliver my baby. I thought she was a obstetrician. (Woman, Nancy)

Notwithstanding that some women recognised both the obstetricians and the midwives ('nurses' in the women's words) as professionals in the maternity services, they weighted the trust of the obstetricians over that of the midwives, even though they were at the low risk status. As raised by 'woman' participant Natalie:

If there is nothing wrong with my labour, it is all right for the nurses [midwives] to care for us. However, when the obstetrician was present in the labour room, I felt more secure. (Woman, Natalie)

Natalie's words reveal a stereotype in the healthcare system that medical doctors represent authority through power and knowledge in comparison with other professionals (Harris et al., 2007). However, midwives' 'nurse' position seems to have enhanced the obstetricians' authority in childbirth, as the service users assumed that obstetricians are the experts in childbirth while midwives (viewed as general nurses) are the subordinates. For midwives themselves, they argued that 'I know I am a midwife' (Direct-entry Midwife Emma TGH), however they also admitted:

[W]omen ... they only know the obstetrician and the nurse. They thought we were just nurses, who can only follow the obstetricians' orders. This is our public image, just nurses. (Direct-entry Midwife Emma TGH)

I think the outsiders (the public) just regard us as a general nurse. Compared to the obstetricians, our status is low. They show higher respect and trust for the obstetricians. (Direct-entry midwife, Jessica SH)

Emma and Jessica's words suggest that the midwives, likewise, have inferred their professional status from the way they were addressed and viewed by the public (particularly their service users). This invisible public image has in effect affected the construction of midwives' professional identity.

Moreover, as the trust relationship between midwives and women has been a central concept to midwifery practice (Lundgren, 2007), the lack of understanding and recognition by the public, particularly the service users, was viewed as a significant obstacle for the midwives to pursue their professional role and develop a clear professional identity in practice (see category 'organisational management' in Chapter Six).

5.3 Discussion: Institutional Position

The study aimed to explore how the hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. Beyond the initial examination of the identity construction, the findings extended to its contextual nature. As Cheung (2011) suggested; to understand the symbolic meaning of 'midwife', the context of this term should be taken into consideration. Findings in this chapter have revealed that the institutional 'nurse' position of the midwives has resulted in their medical preparation, role confusion and invisible public image. In the political sense, such an institutional position has challenged the independent professional status of midwifery, which has formed a contextual condition where the construction of the midwives' professional identity took place.

As discussed in Chapter Three, in the light of traditional sociological standards, midwifery is often categorised as a semi-profession (Parsons, 1939, Abbott, 1988, Foley, 2005), largely the result of power imbalances and jurisdictional subordination when compared with their medical counterparts (Mander, 2002). The category 'institutional position' in this study has revealed that the marginal position of midwifery in the Chinese maternity care system has become a concern to the midwife practitioners. Midwives have attributed their marginal position to the diminished structural boundaries in relation to nursing as well as medicine at the institutional level.

Social identity theorists have evidenced that group categorisation involves a process of comparison with others of the relevant groups e.g. (Ashforth and Mael, 1989, Jenkins, 2008, Andreouli, 2010). In order to construct a distinctive professional identity, a clear jurisdictional boundary is one of the important indicators (Riesch, 2010). This study has indicated that the midwives' formal jurisdiction has been blurred and marginalised by both of their interrelated groups: the medical profession and the nursing profession. The marginalised status of Chinese midwifery has given rise to the identity crisis of the midwives

in terms of where to position themselves in the maternity care system. The following text discusses the category 'institutional position' by explicating the intricate relationship of midwifery with medicine and nursing in China in comparison with the status of midwifery in some other countries.

5.3.1 Inter-group Relationship with Medicine

It has been a challenge for midwifery in many countries, as well as midwifery in China, striving for recognition as a profession e.g. (Donnison, 1988, Mander and Fleming, 2002, Cheung, 2009). The power that medicine exerts over midwifery in the process of midwifery professionalisation has been spotlighted over decades. As one 'face' of the medical oppression discussed in Chapter Three (Young, 1988), marginalisation (jurisdictional exclusion) in this study is evident in the category 'institutional position', which highlighted the struggle that midwives have gone through in defining themselves in relation to the dominant medical profession. Cheung (2011) has suggested that in order to understand the marginality of Chinese midwifery it is essential to examine who defines the boundaries. In the study context, the sub-categories 'medical preparation' and 'role confusion', have explicated the medical influence upon midwifery preparation and the division of labour, which evidence the authoritative power of the medical profession.

As introduced in Chapter Two, western medicine has played an important role in modern Chinese maternity services. It has caused Chinese midwives to be transformed from the traditional midwives central to holistic care, to the modern midwives oriented towards medical approaches (Cheung, 2011). During the modern era, the education and qualification standards of Chinese midwifery have been gradually regulated and evaluated from the medical perspectives. Such institutionalised medical power has inevitably enabled a medical monopoly within the context of Chinese maternity care and has been argued as a contributor to the 'demise' of the midwifery profession in the contemporary time of China (Cheung, 2009: 235). The medical monopoly as such is evident in the category 'medical

preparation'. Though the preparation route varies for different midwives (quasi-obstetrician training midwifery programme in the 1980s; current midwifery programmes; on-the-job midwifery training for the nurse-midwives), the training of midwifery was commented as being mainly medically oriented. In doing so, the 'medical preparation' for the prospective midwives has paved the way for medicine to exercise its ideological power in midwives' professional identity construction.

Since the Chinese healthcare reform in the 1980s, the medical profession, as the emblem of modern biomedical knowledge, has boomed with the support of central government (Harris et al., 2009, Cheung, 2009). The power of the medical profession has been exerted over Chinese midwifery by the way of its impact upon government policy, which is seen in the discontinuation of midwifery education in the 1990s (Cheung et al., 2005) and the subordination of midwifery to the nursing profession in the early 21st century (Wen, 2008). By this means, the medical control over midwifery has begun to exercise through its control over nursing. The institutional nursing position of midwifery in the current maternity care system has thus further ensured that Chinese midwifery remains subordinate to the medical profession. As Cheung (2011: 306) reasoned:

By their unequal opportunity in education, their specification and ranking of their specialisms, midwives were disadvantaged in negotiation with medical professional bodies and the government.

Such institutional change in defining the relationship of Chinese midwifery with medicine is evident in the category of 'role confusion'. The study found that the current institutional position of midwifery has entailed a re-organisation of the division of labour in maternity care systems so that many of the midwives' autonomous practices are allotted to the obstetricians. Hence, the authoritative position of the medical professionals in practice is further strengthened, whilst the midwives' professional autonomy is diminished accordingly. Therefore, with the support of relevant literature and the data in this study, it is safe to argue that Chinese midwives' current institutional position is widely grounded in the

medical discourse with the aim of taking over maternity care as a medical jurisdiction (DeVries, 2001, Robertson, 2002, Harris et al., 2009).

5.3.2 Inter-group Relationship with Nursing

Similar to the history of Chinese midwifery, the origins of midwifery and nursing in many countries were quite distinct. However, in its successive development, there has been a universally intricate connection between midwifery and nursing in terms of regulation, education and organisation e.g. (Donnison, 1988, Borsay and Hunter, 2012, Dawley, 2002, Rooks, 2007). Although how the development of midwifery was accompanied by the nursing group varies in different countries, it has been contended that the intimate link with nursing deteriorates the status of midwifery as an independent profession and prompts midwives' medical orientation in maternity care (Donnison, 1988, Mander, 2002). The nursing influences are reflected significantly in this study owing to the institutional nursing position of midwifery in China. In the analysis of the category 'role confusion', findings revealed that in becoming a sub-branch of nursing, not only did the midwives themselves experienced role confusion, there were also misconceptions of what 'midwife' means in the nursing profession, which supervises midwives' practices.

With regard to the institutional and ideological ties between the two disciplines, the hyphenated nurse-midwifery in the US shares most similarities with the midwives in this study. Different to the origin of Chinese midwifery, American nurse-midwifery was firstly initiated with a blending of practices from nursing and midwifery in the late nineteenth and early twentieth centuries, which functioned to eliminate traditional African-American and immigrant midwives (Dawley, 2002, Dawley, 2005). The history of American nurse-midwifery was viewed as 'a sectarian profession vis-à-vis the dominant profession of nursing' (Dawley, 2005: 149). Although nurse-midwifery in the US has gone through a range of significant movements in its development, the professional status during two social moments are akin to the situation of contemporary midwifery in China: a period of being

dominated by the profession of nursing in the early twentieth century, and being embraced as an extension of nursing practice in the 1970s (Dawley, 2002, Dawley, 2005). For the American nurse-midwives, even though they had established their own organisational bodies for education and standards of practice, the association with nursing still leaves them struggling in the process of identification with midwifery (Dawley, 2002, Rooks, 2007). Olsen (1977) reported that there were misconceptions among the nursing and medical professionals in terms of the role definitions of the nurse-midwife. American nurse-midwives were assumed to encounter role conflicts as they undertook the professional roles of both registered nurse and the nurse-midwife. Drawing on role theory, Hazle (1985) investigated 100 American nurse-midwives and 100 obstetric nurses to explore the issues of role conflicts within the nurse-midwife and between the two groups. The authority and power conflict between nurse-midwives and obstetric nurses was identified as an important issue in the inter-group interactions, while the intra-conflict of the nurse-midwife was not supported by this study (Hazle, 1985).

In looking at Chinese midwifery in the contemporary era, this profession is merged into nursing group, and midwives are regulated under the general Nurses Act (Wen, 2008). The maternity care institution assigns nurse identity to the midwifery group that inevitably involves allocating associated positions and resources (Jenkins, 2008). As indicated in the category 'role confusion', by categorising midwives under the broad 'nurse' title, the maternity care institution has created a tangible hierarchical relationship between the midwifery and the nursing groups, in which the function and specialisms of midwifery were arguably not recognised sufficiently by the nursing profession that directly regulates midwifery practice. From the midwife participants' perspectives, findings in this study have indicated the conflicts of role expectations between the midwives themselves and their nursing managers. As the title of nurse seemed to have influenced the managerial expectations of the midwives, and subsequently the opportunities for them to assume their professional role, the current inter-group relation between midwifery and nursing may also involve a sense of marginality according to Young's (1988) definition.

In the current study, the midwife participants in some hospitals worked in the labour wards alone without direct interaction with the obstetric nurses; while in other maternity units, they took on the role of both the midwives and obstetric nurses. Given such service organisation and the current nurse-position of the midwives, in this study there is no indication of the inter-role conflicts between the practising midwives and the obstetric nurses as faced by the American nurse-midwives (Hazle, 1985), but the intra-role conflicts for the individual midwives were evident in the category 'role confusion'. When exploring the elements of occupational identification, Becker and Carper (1956) identified that one of the important components for work-based identity is the occupational title and the associated meaning (ideology) that the title conveys. In the more recent works on the professional identity of health visitors in the UK, researchers also implied that the title of a profession conveys a message of what the title-holder does (Hunt, 1972). Therefore, a vague title can potentially create uncertainty over the related role and the ambiguity about the professional identity (Baldwin, 2012). In the UK and many other European countries, notwithstanding the association of midwifery with the nursing profession in aspects of regulation, education and organisation, midwives have a legally protected professional title 'midwife' e.g. (Winship, 1996: 41, Kirkham, 1998, Department of Health, 2008). In the United States, however, midwives with a nursing background are legislatively titled as 'nurse-midwife' (Rooks, 2007). This hyphenated title renders a subsidiary position to the midwifery group. In this regard, American nurse-midwives have been in a constant debate about whether they are nursing specialists or independent professionals, whilst there have been concerns of the intra-role conflicts for the American nurse-midwife (Dawley, 2002, Dawley, 2005, Hazle, 1985). The intra-role conflicts for the individual midwives are evident in this study, as the official title of the Chinese midwives has been converted from the previous 'midwife' into the present 'obstetric nurse', and as a result the role of the midwife has been mixed up with the tasks that were previously assigned to the nurses.

Additionally, the category 'role confusion' has also revealed the diversity of the Chinese midwifery group, which is attributed to a mixture of educational and training schemes.

Beyond the seemingly hybridised Chinese nurse-midwives (nursing graduates who are qualified as midwives after a short-term, on-the-job midwifery training), the study also identified another variety of the current midwives: the midwives with previous obstetric experience, which, as we have seen, furthered the role confusion with the Chinese midwives. These midwives, who performed the obstetric skills (such as forceps, vacuum extraction, suturing) before, valued these practices as integral to their professional identity. Such a skill mix within midwifery expertise has caused concern that the use of medical skills may not promote midwifery professionalisation, but rather undermine the midwives' perceptions of their professional identity (Purkis, 2006). Although this study didn't indicate the intragroup conflict as the studies in other context did, the group diversity, represented by the midwives' structural and ideological association with the disciplines of nursing and medicine, is a contributor to the identity crisis of the midwifery profession, as it has the potential to blur the professional boundary and fragment the professional group. In this study, the impact of the diversity of midwifery groups and the medical components in midwifery training upon the ideologies underlying midwifery practice are evident in the professional identity construction of the individual midwives in hospital settings (see Chapters Six and Seven).

5.3.3 Public Image of the Midwife

The findings also revealed the 'invisible public image' of the midwife in contemporary time of Chinese midwifery, which has aggravated the sense of identity crisis for the profession. According to identity theory, the construction of one's social identity is adjusted through a process of 'self-verification' whereby individuals compare their own identity constructs or standards with the feedback from others with whom they interact (Burke and Stets, 2009: 232). As a significant reference group, this study found that women clients' feedback has the power to influence how the midwives view themselves.

The study identified two interrelated root causes for the invisibility of the Chinese midwives to the public. One is the contemporary public reliance on, and trust in, the authority of

medical 'experts' in China and elsewhere with regard to their ideological power and knowledge over other health professions in the healthcare system, particularly in hospital settings (Harris et al., 2007). It gave rise to a public misconception of the role of the midwife and ultimately relegated midwives to the position of obstetrician's assistants. This ill-defined public image of midwifery and its impinging on the professional identity construction in midwives have also aroused concerns in a wide range of midwifery contexts. Similar to findings in this study, the report to the Department of Health Children's Taskforce from the Maternity and Neonatal Workforce Group (2003: 8) reflected that even in the UK, 'some women may not fully understand the range of competencies of a qualified midwife and the care which they can provide'. Purkis (2006) commented that in 2006 UK national news reports described that increasingly hospital-based midwifery care has led to the public views of midwifery as being akin to nursing, whilst the two terms have been used interchangeably in many aspects of public life. This situation seems to have changed markedly in the UK due to the recent epidemic of exposure of midwifery in popular media, whereas in China such means of publicity are often used to promote the social status of obstetricians and the medicalisation of childbirth (see Chapter Six).

In addition to this almost universal cause, midwives in this study highly associated their invisible public image to their current nursing position in the maternity care system. This institution-categorised and policy-oriented nursing position were claimed to have eclipsed the role and functions of the midwives to the public and have in turn strengthened the 'expert' status and power of the obstetricians.

5.4 Conclusion: Institutional Position and Midwifery Identity

Midwives in this study have commented that in being regulated by the maternity care institution they were required to come to terms with their institutional nurse position. The empirical evidence presented by the category 'institutional position' supports scholars' statements that contemporary Chinese midwifery is in a marginalised status (Cheung, 2009,

Tan, 2010), and revealed that midwives were in a state of struggling in defining themselves in the maternity care system. With regard to the category 'institutional position', the structural context of contemporary Chinese midwifery was discussed and compared with the broader midwifery settings in other countries. It indicated that the institutional context of midwifery in China shares many similarities with other countries where midwifery seems to be well developed. However, as revealed in this study, an essential barrier that prevented midwives from identifying with a clear and strong professional identity is the midwifery position in the maternity care system, which is in a state of marginalisation not only in relation to the profession of medicine but also to the profession of nursing. There was a strong sense of identity crisis for the midwifery profession emerging in this study. As ICM Global Standards for Midwifery Regulation (2011b: 7) recommended, in order to 'enable autonomous midwifery practice and ensure high quality midwifery care for mothers and babies', a separate regulatory body for midwifery is necessary; while 'as a step towards midwifery-specific regulation the separate professional identity of midwives must be recognised in any regulatory processes'. For contemporary Chinese midwifery, it is of concern that the professional identity crisis cannot be radically resolved unless their independent professional status can be achieved with the support of government and the client group.

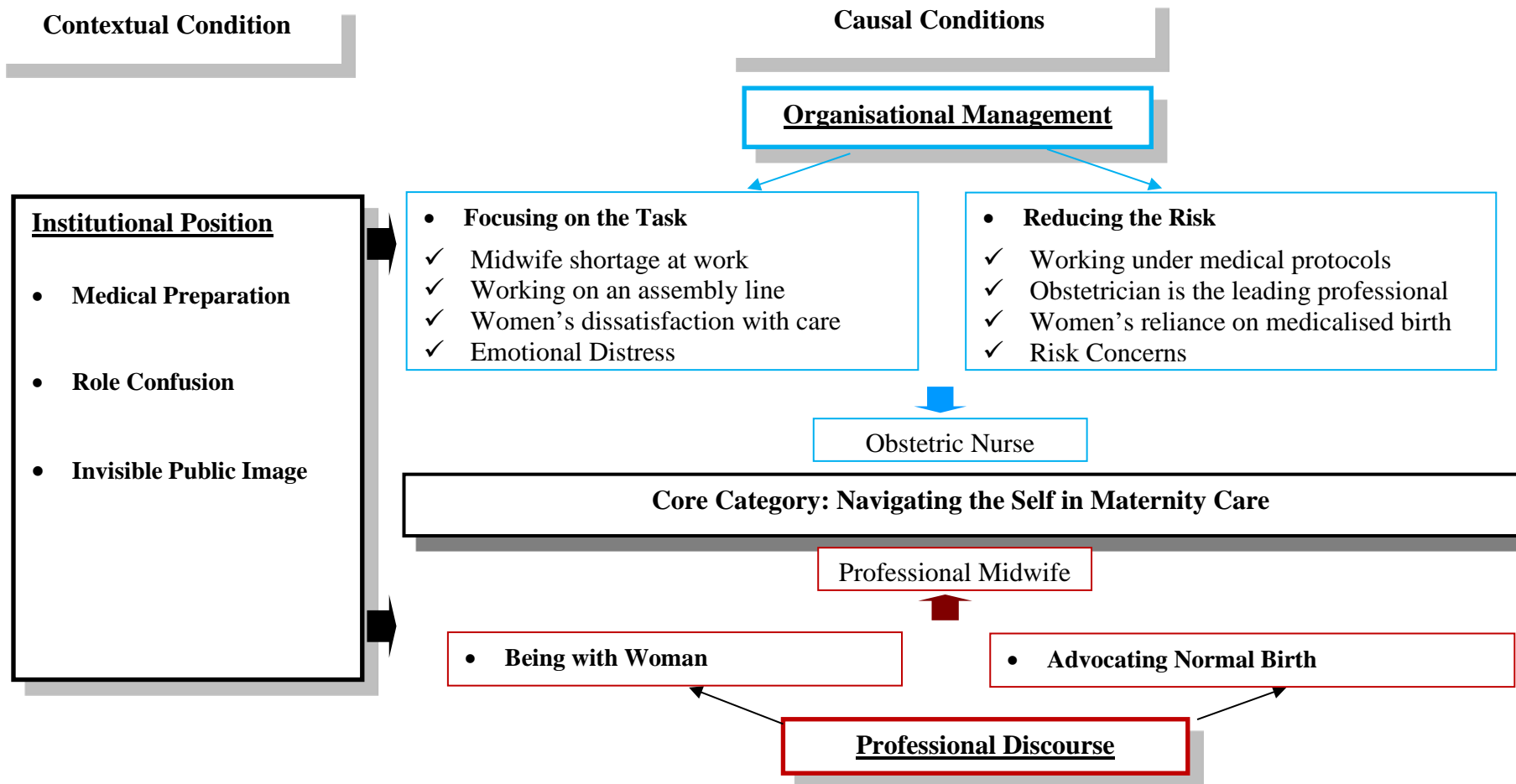
The findings in this chapter have revealed that the professional identity construction of the hospital-based Chinese midwives is contextualised in its marginalised 'institutional position' with regard to their medical preparation role confusion and the invisible public image. In the next chapter, the ideologies underlying midwifery practice in the organisational context will be examined with the analysis of two categories 'organisational management' and 'professional discourse'. The influences of the 'institutional position' upon the 'organisational management' and 'professional discourse' are examined concurrently.

CHAPTER SIX: CAUSAL CONDITIONS – IDEOLOGIES UNDERLYING MIDWIFERY PRACTICE AT THE ORGANISATIONAL LEVEL

6.1 Introduction

In Chapter Five, midwifery status at the institutional level was analysed and discussed with regard to the 'institutional position' category, which formed the contextual condition for professional identity construction. This chapter further examines the causal conditions that determine how individual midwives construct their professional identity in hospital settings, with regard to the conflicting ideologies underlying midwifery practice at the organisational level. Two principle categories, 'organisational management' and 'professional discourse', are analysed to this end (see Figure 5). The 'organisational management' category reveals the bureaucratic and hierarchical nature of the hospital settings, where the role of the midwife was constrained by the organisational demands of 'focusing on the task' and 'reducing the risk'. 'Professional discourse' presents the ideological constructs of 'being with woman' and 'advocating normal birth' that midwives identified as defining their professional identity in practice. The two categories 'organisational management' and 'professional discourse' represent the conflicting ideologies that underlie hospital midwives' practice, demonstrating the interplay between the external definition (the 'obstetric nurse' defined by the work organisation) and the internal definition (the 'professional midwife' defined by the profession) of the midwife. The sense of identity-dissonance ('emotional distress' and 'risk concerns') in the hospital-based midwives emerged as a result. Along with the analysis of the two categories, the institutional impacts ('institutional position') are also examined. With reference to the relevant literature, findings are discussed at the end of this chapter.

Figure 5: Causal Conditions - Ideologies underlying Midwifery Practice at the Organisational Level



6.2 Organisational Management

The 'organisational management' category explicates the organisational demands in hospital settings where midwives worked, forming one of the causal categories determining influencing the construction of midwives' professional identity in hospital settings. It comprises of two subcategories, 'focusing on the task' and 'reducing the risk', representing how midwives' identities at work were bound up with the ideology in their work organisations aimed at task-completion and risk reduction. As such organisational management went against the professional ideology of midwifery (being with woman and advocating normal birth, analysed in section 6.3), the 'emotional distress' and 'risk concerns' of midwives were triggered.

6.2.1. Focusing on the Task

The subcategory 'focusing on the task' reflects the bureaucratic management in hospital settings, where the identity of the midwife is tied to the work role of focusing on the organisationally allocated tasks. Midwives commented that many of the important decisions concerning midwifery care and resources were made by the administration based on the organisational principle of clinical efficiency, whereas the core value of midwifery care ('being with woman' see Section 6.3.1) was not recognised as sufficiently worthwhile. The role of the midwife was bound by the structure of the working context, which is characterised by the codes 'midwife shortage at work', 'working on an assembly line' and 'women's dissatisfaction with care'. Practicing under the context, the management of which was often against the professional ideology of midwifery (being with woman), has caused 'emotional distress' to the midwives.

6.2.1.1 Midwife Shortage at Work

With regard to the category 'role confusion' discussed in Chapter Five, midwives indicated that their 'nurse' position had entailed mixing-up their role with the practices of the nurses, and masked their specialised knowledge and skills to the people outside of their group. This institutional influence is reflected in the management of the midwives' workplace, as midwife participants expressed a strong perception of midwife shortages at work, which they attributed to the lack of acknowledgment of their professional role at the managerial level in their work organisations.

During data collection for this study in 2010, the number of employed midwives in the study sites was 50 in the TMH, 42 in the TGH and 10 on average in the SHs, with the corresponding 10,000, 6000 and 2500 average number of births per year in each hospital. Midwife participants, in all the hospitals studied, unanimously commented that the current midwife staffing at work barely allowed them to complete the basic tasks for 'the physical safety of the mother and baby':

In our unit, the number of births is more than 10,000 per year. The midwives are insufficient compared to the large number of childbirths. We are unable to provide one-to-one care. The current staffing can only allow us to work during labour and birth and complete the basic tasks. (Direct-entry midwife, Emily (TMH))

In total, there are 42 midwives in our unit. Excluding those on wedding or maternity leave, only 38-39 are on the job. Even based on the standards of nurse/bed ratio in China, we are far from enough, let alone compared to the midwife/birth ratio standards in other developed countries. Truly, you can hardly imagine the situation during night shift. On the day shift, there are usually seven-to-eight midwives, but at night only three. If you need to take care of seven or eight labouring women at night, it is impossible to give sufficient support and care. We can only focus the physical safety of the mother and baby, no accidents. (Direct-entry midwife, Emma (TGH))

There are ten midwives in our unit, but we have to cover a wide range of tasks including labour wards, obstetric wards, sometimes in gynaecological wards. In the daytime, one midwife takes charge of the labour room, six beds altogether. (Direct-entry midwife, Jessica (SH))

Midwives' comments indicated a split of the evaluation for midwife staffing allocation between the tenet of midwifery care and the necessity for organisational operation. From the midwives' ideological point of view, the existing midwife staffing that was calculated on the basis of physical safety of woman and baby was far from the optimal service. Integral to midwifery care, there are more invisible services beyond the basic routine tasks, which midwives termed 'humane services' (e.g. direct-entry midwife Linda, THM), requiring their continuous availability to women. In terms of the time and efforts invested in care provision, midwives argued that their workload should be comparable to that in the operating theatre or intensive care unit:

Women's needs for psychological, emotional and information support are commonly overlooked. Our workload can be compared to what the nurses do in operating theatres and ICUs [intensive care units]. However, included in the official evaluation standards of the tertiary hospital, there are exceptional standards of nurse staffing in these departments [operating theatres and ICUs], but nothing specific for maternity units. So, the existing workforce can hardly allow the quality of care for women. (Direct-entry midwife, Linda (TGH))

All midwife participants expressed their dissatisfaction with the present number of midwives at work, as it cannot allow them to provide sufficient care to their service users.

As to the midwifery staffing allocation, midwives implied that it was the administration in their work organisations that controlled, while the managers were perceived as not considering the role of 'humane services' in midwifery care as sufficiently worthwhile. The 'humane services' were claimed to be integral to the midwifery ideology of 'being with woman' that has been evidenced as the central tenet of midwifery care (Hunter, 2002), yet its intangible quality is hardly measured and seems to be incompatible to the organisational evaluations for clinical efficiency, as reflected in Catherine's words:

The problem of staffing shortages has always been around in nursing. For midwives, it is even worse. If it keeps up in this way, it is impossible to guarantee the quality of midwifery care. This managerial level in the hospital doesn't fully understand what midwifery care or a midwife is. The low midwife staffing is the salient example. The managers allocate resources based merely on the safety [physical] concern. In my opinion, our practice scope is broader than the technical tasks required in the traditional [medical] model. However, when I tried to lobby the managers, they didn't seem to be convinced. They told me 'the traditional model has been used for so many years, everything is fine. Even if we don't have enough midwives, we will just continue as we are. (Direct-entry midwife, Catherine (TGH))

In Catherine's words, the contradiction between the organisational target of focusing on the task and professional ideology of being with woman is evident. As the literature indicated, the contemporary healthcare system in China is largely privatised whilst the hospitals are heavily market-driven institutions (Blumenthal and Hsiao, 2005). Under the present conditions, the traditional medical model seems to be viewed by the administration as the optimal approach to meeting the organisational goal for clinical efficiency and profit incentive. It, however, in midwives' eyes, fails to recognise the value of midwifery care that goes beyond purely completing technical tasks. The quote 'if we don't have enough midwives, we will just continue as we are' reflects the bureaucratic management in the work organisations and strong organisational control over the role of the midwife.

In addition to the less supportive hospital administration, midwives raised that their direct supervisors in nursing departments seemed also to overlook the role that caring and 'humane services' can play in midwives' work, particularly in the general hospital, as Emma said:

The nursing managers think there is nothing special about midwives' work or being a midwife when the medical and surgical departments, and the maternity unit are all short of staffing. The medical or surgical departments would certainly get attention and staffing support from the administration. This is the whole concept from the top down. It takes time to change. (Direct-entry midwife, Emma (TGH))

Midwives indicated that their work performance was assessed by the current framework of obstetric nursing standards, which is focused on the technical aspects, but with little, or only general, concern for emotional and informational support for women. While the role of the midwife was regulated almost identically to that of an obstetric nurse by the administration from the top down, what midwives perceived as indispensable to midwifery care, and of being a midwife, appeared to be continuously undervalued in the workplace, making them feel frustrated when seeing their role becoming purely technical.

The feeling of frustration of not being able to pursue their professional ideal was constantly intensified by increasingly international communication: when they compared the staffing ratios to that in some western countries. Taking Lena for example:

In 2008, a team of midwives from the US came to our unit for a visit. We found we had similar numbers of annual births, but the staffing ratio had a big difference. For them, one midwife was in charge of one LDR [labour & delivery room]. They can provide one-to-one care for women, but our staffing ratio couldn't allow it. It is really frustrating. (Nurse-midwife, Lena (TMH))

With increasingly international communication, such midwifery discourse has been continuously brought into Chinese midwives' narratives. Although there are pros and cons of midwifery care in every country, such comparisons with midwife counterparts outside of their own community seems to stimulate midwives' reflections of themselves, which in turn magnifies their dissatisfaction with their current working context.

6.2.1.2 Working on an Assembly Line

Midwife participants commented that the current number of midwives at work made them often carry a high-volume workload; 'working on an assembly line'. This code explains how the midwives acted as the technicians at work by being constrained by the heavy workload and their struggle to deliver effective care to service users.

The current daily workload, as midwives described, was like working on a rushed assembly line, wherein they functioned as technicians: 'running between tasks all the time', 'terribly busy', 'being overwhelmed by the tasks and the needs of everyone' (women, obstetricians and colleagues), were the phrases that midwives used constantly to express their stress under the over-allocated workload. In the study hospitals, midwives said that even though they had already been kept busy, they could barely complete their technical routine within the limited work timescale, hardly satisfying anyone. Expressions such as 'exhausted' and 'draining' occurred frequently in the interviews:

In the hospital, especially in the labour wards, bed turnover is very fast, like an assembly line with women in and out ... we are always terribly busy during work. It seems that everyone needs me, women, obstetricians as well as our colleagues. For example, one day during my day shift, 13 women were going to give birth. While I was occupied by the overwhelming amount of routine tasks, the obstetrician hastened me to assist her and women asked for other things. I just wished I could split myself. This happens more often during night shifts. It left me exhausted. (Nurse-midwife, Fiona (TGH))

The existing management makes midwives feel that they are struggling to achieve their professional ideology of being with woman, as they have to divide their time between each work routine to provide basic possible care for all. Particularly, midwives spoke about the higher amount of workload not only hindering them from delivering optimal care to women, but it had impinged on their competence in safeguarding women and babies. They commented that midwifery care needed them to be discerning of the complex situations when caring for labouring women, which required their 100 per cent concentration and their availability to women. Current working conditions, however, make midwives overwhelmed by the heavy workload, while the time that they spent with individual woman is inevitably restricted, leading to the sense of insecurity in their practice:

There are eight beds in the labour wards, but usually three to four extra beds are allowed. During night shift, only one midwife takes care of all the labouring women. According to the hospital protocols, foetus heart

monitoring requires being conducted every hour. If there are 15 to 16 women there, it will take me more than half an hour just for the monitoring. I also need to do other things, like recording medical case notes, giving medication and some primary care for women, as the family members are not allowed in the labour room. I can only do a little here and a little there. In fact, I couldn't attend each one fully. However, midwifery care is high-risk work and requires 100 per cent concentration during work time. The high-intensity work makes me quite stressed at work and drags me down sometimes. (Nurse-midwife, Juliet (TMH))

Existing organisational management, it is claimed, besieges midwives with a large volume of allocated tasks, which constrain them in the task-oriented approach to care. As a consequence, midwives become less able to exercise professional discretion and even feel insecure in their practice. The current working conditions have led to a range of negative emotional reactions. As Lena said, she was 'kept in a state of high concentration and running between tasks all the time', felt 'stressed, anxious and exhausted quite often' and sometimes 'even irritated' (Nurse-midwife Lena TMH).

6.2.1.3 Women's Dissatisfaction with Care

In this study, conversations with the midwife and women participants imply the current tense relationship between midwives and their service users. The code 'women's dissatisfaction with care' here describes the tension between midwives and women clients resulting from the discrepancy between the task-oriented care management in the work organisations and the individualised care needs from the service users, and its impacts upon midwives' work strains.

Mary's words give an example of the conflict that is caused by the gap between the women's needs for individualised care and the hospitals' universalised task management.

I understand every woman is an individual. She has her own expectations and needs us to be there with her. However, there is the conflict. For us we need to equally distribute our limited time to everyone. From a woman's point of view, she needs us to give all time to her. The reality is,

we are only allowed to provide average possible care to each one. Here is the gap. Under such circumstances, if something goes wrong with the childbirth or the woman has to have a caesarean at the end, we are usually complained about for not providing enough care. (Nurse-midwife, Mary (TMH))

Studies have revealed that since Chinese healthcare reforms in the early 1980s, whereby patients pay directly for a portion of their care, for some the increasingly privatised health-care system has enlarged service users' consumerist awareness and their expectations of care provision (Blumenthal and Hsiao, 2005). Health care organisations, on the other hand, fail to meet the patients' growing needs, resulting in the changing relationship between healthcare professionals and service users over the last decades (Blumenthal and Hsiao, 2005), as Jessica and Ellen stated:

Different to women twenty years ago, they [women] are more knowledgeable now. Some of them are becoming more demanding, taking our care for granted. (Direct-entry midwife, Jessica (SH))

Nowadays, women consider themselves as service consumers. As long as they pay, we should offer the services they asked for ... better care ... less pain ... and everything should go well. But you know, we couldn't guarantee this, especially in a busy hospital [...] There's nothing wrong with putting women's needs first as long as our working conditions can be considered as well. (Nurse-midwife, Ellen (TGH))

The above excerpts from midwife participants' words reveal a growing tension in midwife-woman relationships due to the conflict between the consumerist demands and the existing organisational management. Midwives in the study expressed their understandings of the women and their families' complaints, yet they also conveyed their desire for sympathy. However, mutual understanding hardly seems to be achieved in the current hospital settings. In the following scenario, from both the midwives and service users' perspectives, Juliet explained how the midwives were caught in the dilemma between work organisation and their women clients:

Family members cannot stay in the labour ward. Usually, the woman is transferred into a labour ward from two centimetre dilation and stays till two hours after birth. The length of her stay in the labour ward is around 4 to 15 hours. During this period of time, her family cannot see her. They can talk over the phone. Under such conditions, they [family] were worried whether we were taking good care of her [the woman]. You know, we are too busy to be there with her all the time. When her husband calls, she complains that the pain is killing her but no one cares. Sometimes, she just complains because of the labour pain, but it is easy to upset her family. You know, they are very worried already. When they hear no one is caring for the woman, especially when they are informed that an instrumental delivery or caesarean is needed, some families had crashed the door open and questioned us. 'Why is my wife's labour taking so long? Why does no one take care of her? You must guarantee everything is going well, or else you will be in trouble.' Such incidents happen quite often. We know that if we had time to support the woman and communicate with her family, there wouldn't be conflict like this. However, we just don't have that time. (Nurse-midwife, Juliet (TMH))

In this description, Juliet indicated the resource deficiencies in the hospital settings, including the limited facilities (rooms) and the inadequate midwifery staffing. On the one hand, the facility cannot offer enough space for birth companions (usually families) to be with the woman during labour and birth (only in one midwife-led labour room in TGH can one birth companion attend the whole process of the woman's birth). On the other hand, the number of midwives at work cannot give continuous care to the women and communicate with their family. The gap between the organisational management and the women's needs is salient, giving rise to the phenomenon that the midwives complain of being overloaded with work whilst the service users blame midwives for not taking good care of them. The deficiency in the system creates the clash between midwives and women as a result. The issues around the tense midwife-woman relationship will be further discussed in section 6.2.2.3 by drawing on women participants' accounts.

6.2.1.4 Emotional Distress

‘Emotional distress’ refers to a range of negative emotions resulting from the current organisational management, ‘focusing on the task’. The situation whereby midwives are not able to perform to their professional ideals not only makes them frustrated by feeling they are becoming technicians, but also puts them in a constant dilemma between organisational demands and the service users’ care needs.

‘Frustration’ was the word often used by midwives to express their feelings when their professional ideal of ‘being with woman’ was claimed to not being acknowledged by the administration in work organisations. Together with the high volume workload, the feelings of ‘being drained’, ‘exhaustion’ and a ‘sense of insecurity’ were added to their emotional strain. The sense of ‘burnout’ was explicit when the midwives mentioned that they had made every effort to provide care for the women, even with ‘no time to drink water or go to toilet’, but such ‘draining work’ instead brought occasional complaints:

You know what? It is a really draining job. I almost have no time to drink water or go to the toilet during night shifts. You can’t imagine. It is crazily busy. [Long sigh]. We [midwives] also complain in private we at least need understanding [from the clients]. (Midwife, Anne (SH))

Last year there was a woman. Her baby was not well after birth and was given CPR. She complained that we didn’t provide her with enough care and she complained about us. We feel wronged. We can’t be there with her all the time, though we really want to do so. There are other women waiting. You see, we tried our best to do everything we could, but for the woman, she needed 100 per cent attention. If she is not satisfied and then something goes wrong during childbirth, she blames us. (Midwife, Fiona (TGH))

Within the current policy and the organisational climate, the professional ideology of ‘being with woman’ seems to be viewed as an option that midwives can only achieve when the organisationally allocated resources and workload are balanced. The lack of support from the administration in their workplaces and the consequent overload of work gave rise to the

midwives' dissatisfactions with the current organisational management. The negative emotions were aggravated by the discontent from their service users. The resultant feeling of burnout has the potential to render midwives task-focused in practice, and subsequently this affects the construction of individual midwives' professional identity (see section 7.2 'compromising strategies').

6.2.2 Reducing the Risk

The subcategory 'reducing the risk' describes the hierarchical work environment under the medical model, where midwives' identity is attached to the work role of achieving organisational goals for risk reduction. Midwives commented that reducing risk was the central focus in the current climate of the maternity care system, where their professional ideal ('advocating normal birth' see Section 6.1.2.2) was constantly undermined. The role of the midwife is bound by the structure of the working context, which is manifest in the codes of 'working under medical protocols', 'obstetrician is the leading professional' and 'women's reliance on medicalised birth'. Working under the context, the management of which was constantly against the midwifery ideology of advocating normal birth, has aroused midwives' 'risk concerns'.

6.2.2.1 Working under Medical Protocols

In terms of the category 'medical preparation' discussed in Chapter Five, midwives indicated the medical dominance in their school education and on-the-job training. At the organisational level, medical power keeps on impacting upon midwives' role performance in their workplaces, as midwife participants commented that their work protocols were formulated firmly under the medical model, which confined their role performance within a strict 'normal' timeframe of childbirth and the subsequent intervening procedures. The code 'working under medical protocols' depicts how the role of the midwife is restricted by these medical protocols at work.

In the following excerpts, Catherine commented that the standard of 'normal' length of labour and birth was narrowly defined in the midwifery textbooks and by the hospital protocols:

In our practice, the length of normal labour and birth is prescribed by the hospital protocols and the midwifery textbooks. The process of labour and birth is divided into three stages. There are strict time parameters for each one. The first stage of labour is divided into the latent phase [from regular contractions to 3cm cervical dilation] and the active phase [from 3cm cervical dilation to 10cm cervical dilation]. For primipara, the latent phase shouldn't exceed 16 hours while 8 hours maximum for the active phase. The second stage is no more than two hours [the multiparous woman may have a second stage of 15 minutes or less and one hour is recommended as the limit]. The duration of the third stage is between 10 and 20 minutes, and 30 minutes is recommended as the limit. (Direct-entry midwife, Catherine (TGH))

This 'normal' timeframe is guided by the worldwide package of 'Active Management of Labour' (AML) (O'Driscoll et al., 1993), which has been criticised by many social and midwifery scholars in terms of its scientific rationale and its undermining of the autonomy of labouring women and the midwifery practitioners e.g. (Percival, 1970, DeVries, 2001, Young, 2009). The constraint of such medical standards on midwifery practice was brought up in this study. Taking Lena for example:

According to the protocol, the second stage of labour is not allowed to exceed two hours. I know in some other countries there is no such strict time limit, so they can wait. However, here, if you find the contraction becomes weak, oxytocin will be given right away. You know, in just two hours, time flies. We are not allowed to miss a single minute. (Nurse-midwife, Lena (TMH))

In Lena's words, her disagreement with the medical protocols in relation to its firm timing and control of childbirth is implied. Such compulsory protocols seem to create an environment where women's birthing is regulated by clockwork, and so the role of the midwife. In comparison with counterparts who were viewed as having relatively supportive work environments in countries such as the UK, Lena reflected on her own practice and

articulated that their professional ideology of advocating normal birth was constrained by the medical protocols.

Drawing on this standardised 'normal' length, midwives stated that any labour and births that deviated from the time limits were deemed as at 'risk'. With the primary concern of reducing any occurrence of adverse events in the hospital setting, early interventions (like artificial rupture of membranes and the administration of oxytocin) prior to the time threshold comes to be the hospital routine, as midwives implied: 'speeding up is routine', 'the faster, the better'. Such an interventionist environment arouses the sense of conflict in the midwives' daily practice between the midwifery ideology of being patient and the medical protocols of taking action, as indicated in Juliet's words:

I know midwives in many countries try more natural ways to help women. In China, we have to follow the medical protocol strictly. The principle here is 'the faster, the better'. I know if we can be patient and wait and let women walk and move, the contractions would accelerate naturally. In our unit, however, speeding up is routine. Once the contraction becomes weak, oxytocin is given. (Nurse-midwife, Juliet (TMH))

Such medical protocols of 'speeding up' were echoed by Emma in another hospital. Although one labour room in this work setting is operated under the midwifery model, the medical model dominant in midwifery practice was claimed to be still persistent in the whole working environment:

There is only one major target. It is to control labour and keep it as fast as possible. Her contraction is not strong enough, do an artificial rupture of membranes. ... This is our entire environment. (Direct-entry midwife, Emma (TGH))

During interviews, midwives often presented themselves as knowledgeable professionals and being willing to 'facilitate childbirth as normally as it should be' (Direct-entry midwife, Catherine (TGH)). However, they also indicated that the priority in their work organisations

was to control and shorten the process of labour and birth. Common procedures such as artificial rupture of the membranes, augmentation (especially oxytocin), and even caesarean section, had become 'normal'. It seems that in the hospitals, what is of most concern is the artificial time parameter, rather than the natural rhythms of individual women's bodies, wherein midwives felt powerless to hold their professional ideals of waiting for the birth.

As for medical procedures, midwives expressed their awareness that over-interventions indeed do more harm than good to the well-being of the woman and her baby (discussed in section 6.3.2). However, as part of the medical system, they felt obliged to adapt to approaches that were different to their preferences; otherwise they have to 'take responsibility for any poor outcomes on our own' (Nurse-midwife Juliet, TMH).

This is the protocol for our practice. The length of the labour is rigorously defined. If we attempt to extend it and there is something wrong during childbirth, we couldn't justify ourselves in the legal dispute, right? You know ... this is the reality we must face. (Midwife, Fiona (TGH))

The precise timing and control of childbirth is representative of the dominant medical culture, which sounds an alarm bell to keep reminding midwives of the risk of litigation, if it is in any way violated. It implies that, if by referencing their professional judgement midwives try to exceed this 'normal' time threshold and wait, they have to prepare for encountering a potential predicament – no legitimate evidence could support them in the legal dispute if something goes wrong. With the legislative use of medical protocols, midwives' professional ideals of advocating normal childbirth seem to be subjugated to the concerns of the risk that any violation of the medical protocols hints at the consequences of the medical legal system.

6.2.2.2 Obstetrician is the Leading Professional

In the light of the 'role confusion' category discussed in Chapter Five, midwives expressed a sense of identity crisis as the institutional nursing position had challenged their professional

status by restricting their scope of practice and empowering the obstetricians. Such institutional impacts are reflected in the workplace, where midwives felt that it was hard to make their professional decisions heard when working with obstetricians. The code 'obstetrician is the leading professional' explains how the professional autonomy of the midwives is oppressed under the obstetricians' authority in practice, while midwives are placed in a position of obstetricians' assistants.

In the analysis of Chinese midwifery professionalisation, Cheung (2011: 302) has argued that the perception that 'doctor knows best' was assumed and reflected in maternity policy (Li et al., 2003). Such institutional power of medical doctors is reflected in the hospital settings, as midwives in this study depicted their subordinate position to the obstetricians in the hierarchical order of the hospitals, which highlighted the power imbalance between the two parties:

Obstetricians are the leading professional. We don't have much power to make decisions. Especially for the experienced obstetricians, they don't like us to give opinions. (Nurse-midwife, Yvonne (TGH))

Basically, we have no power to reject their medical orders. They are the decision makers. We are more like the followers. (Nurse-midwife, Maya (SH))

Working under the medical model, midwives felt not having a strong sense of agency to make their clinical decisions. Midwives said when there was a disagreement on the clinical judgements between a midwife and an obstetrician, the midwife was often the one who made the compromise. Taking Jenny's experiences (quotes from her work journal) for example:

I run into a moment of conflict with a obstetrician yesterday. She asked me to prepare the delivery bed and deliver the baby, but according to my experience, I think it is too early. I told her we could wait a bit longer and let the woman's body get ready, but she insisted. As I had 17 years' experiences of doing midwifery, I have developed the expertise in this

area. When I worked in the two health centres in rural area, I practised on my own. These experiences awarded me with the capacity to gain the instinct and acuity of how women's labour progresses. So, I tried to communicate with the obstetrician, tell her my opinion, and suggested that she needed to reconsider her order.

I think most of the midwives may not do this, because they assumed obstetricians know better. If I do not have 17 years' midwifery experience and have the managerial position, I may not have done this either, as obstetricians also have the power to supervise our work.

In this case, the obstetrician finally got annoyed as I disagreed with her. In the end, I had to compromise. It was really a frustrating experience. As a professional midwife, I have expertise in assisting normal birth. I have the competence in assessing women's labour progress. Obstetricians and we are supposed to work together to achieve the best interest for women. However, it seems like that we should behave as the obstetricians' assistants, passively following their orders. So, shall I hold on my professional opinion and try to negotiate with the obstetricians next time or just leave my judgement aside? (Direct-entry midwife, Jenny (SH))

Jenny has 17 years' midwifery experience. She indicated her working experiences and sense of leadership enabled her to challenge the obstetrician's authority. However, as obstetricians stand for the medical protocols in the hierarchical hospital settings, midwives' compromise was claimed often to be the case in such encounters. The compromises as such seem to significantly affect midwives' professional sense of self, as Jenny said; she felt she was expected to be 'the obstetrician's assistant' and 'the follower'.

There have been historical debates in nursing literature that less room is available for nurses to make decisions under the medical doctors' authority e.g. (Sweet and Norman, 1995, Hunter, 2004). The phenomenon is evident in this study in that midwives' institutional nursing position has further legitimated obstetricians in taking over control of the normal birth domain, which is supposed to be the midwives' professional jurisdiction. Being positioned as a nurse passively following obstetricians' orders has become a convention for most midwives: equal communication and collaboration between obstetricians and

midwives seems to be less achievable in midwives' perceptions. Such perceptions are stronger in the accounts of the nurse-midwives:

We are under the management of nursing, so obstetricians treat us just as a general nurse, don't regard us as a midwife with autonomy in normal birth. (Nurse-midwife, Mary (TMH))

We [obstetricians and midwives] don't have much intersection in terms of authority. They are entitled to supervise us. We may be able to remind the obstetricians of some decisions, but only when it is appropriate. We don't have power at all. (Nurse-midwife, Yvonne (TGH))

Some midwife participants indeed commented that the experienced midwives were likely to achieve equal communication with the obstetricians. Nonetheless, midwives also acknowledged that they had to concede to the medical protocols if this was the centre of the contradiction, as Daisy implied:

Fifteen minutes, nine centimetres dilated; half an hour, nine centimetres. That's fine. When one hour passed, still nine centimetres dilated. She [the obstetrician] stepped in and managed the labour in her way. It was frustrating. I felt like I was losing power. After spending time and effort in taking care of the woman, she [the woman] has to suffer the intervention. They [obstetricians, colleagues and women] probably would judge my expertise. (Direct-entry midwife, Daisy (TGH))

This incident happened in the midwife-led labour room, where midwives' professional autonomy appeared to be also liable to the control of the obstetricians in the name of medical protocols. Such experiences have the potential to decrease midwives' confidence in advocating normal birth, and subsequently undermine their established professional ideology. As Daisy commented:

The philosophy in the midwife-led unit is being imperceptibly reversed within such an environment. Slowly but surely. (Direct-entry midwife, Daisy (TGH))

6.2.2.3 Women's Reliance on Medicalised Birth

The category 'invisible public image' in Chapter Five has revealed that women participants were lacking in understanding of the midwives' professional role and assumed obstetricians to be the experts in childbirth. Such an 'invisible public image' has impeded midwives' role performance in advocating normal birth in practice, which is reflected in the code 'women's reliance on medicalised birth'. The code 'women's reliance on medicalised birth' explains how medical power inhibited midwives from being able to pursue their professional ideals of advocating normal birth through its impact upon women's choices on childbirth.

Midwives commented that being exposed to medical discourse of viewing childbirth as a potential risk, women appeared to incline to the medical orientation of childbirth. Midwives described, 'demanding caesareans' and 'requests for intervention' became the 'common scene' in their daily interaction with the women and their families. Women's reliance on medical interventions was viewed as one of the significant inhibitors for midwives to support normal birth, as it can intensify midwives' risk concerns in terms of the potential legal disputes, as Mary said:

'I have been in pain for such a long time. I can't do it anymore. I need surgery... If you don't give me a caesarean, you must be prepared to take responsibility for any bad outcomes.' This is the scenario that happens almost every day in our work. (Nurse-midwife, Mary (TMH))

A number of the clients' demands for the medical way of birth, and the occasional incidents of the aforementioned confrontations, were echoed by all midwife participants. The current study does not aim to clarify reasons behind the maternal requests for medical interventions. However, since the women's requests for medicalised births, as the study suggested, have prevented midwives from carrying out their professional role to support normal births, there is a need to understand the part that medical discourse and the hospital service organisations have played in this phenomenon.

Apart from the prevailing use of the medical model in the maternity system, women participants indicated that publicity from the media and their acquaintances' birth experiences had increased medical technology's appeal to the women and their families:

I've seen an online video about caesareans. The mother was anaesthetised but she was conscious. The baby came out very quickly. The procedure seems very safe and quick. There is no need to suffer much pain. (Woman, Nancy)

I've planned to give birth by myself and I know it is better for my baby. But, many of my friends and the people I know give birth by surgery. They told me if trying normal birth, I may end up with surgery after suffering labour pain. (Woman, Joanna)

Because of the one-child policy, it is difficult for the woman who only gives birth once to know how different childbirth experiences can be with different birth choices. The medical-technological childbirth, however, has been successfully propagandised as an 'ideal means' to lay people who are eager to conquer their fear of labour pain and the uncertainty about childbirth:

The pain seemed to last forever. I couldn't stand it anymore. I just needed something to end it. Even though I know it is good for us to have normal births, I'd rather take the caesarean. After all, they are not that bad. (Woman, Natalie)

It is evident that medical discourse has a powerful influence on women's choice of childbirth. Similar to the study on caesarean sections in China (Zhang et al., 2008), in this study midwives perceived women's requests for caesareans as being often related to their lack of tolerance for risk due to the one-child family policy and/or their fear of labour pain. However, the underlying problems of midwives' reduced accessibility, overcrowded birth environments and limited support were more explicitly addressed by women participants in this study. When recalling the birth experience, Claire expressed her feelings of loneliness when waiting in a labour room whilst midwives were occupied by technical work rather than being available for her:

I needed some instructions but they were just busy with something else. It really upset me. I was totally lost. (Woman, Claire)

Sophie also described her disappointment as feeling being abandoned when the midwife was unable to be there for her.

It was a real disappointment to feel alone. I found that the midwife just wasn't there. I felt abandoned ... having to be on my own ... I grasped the sheets every time the pain came. (Woman, Sophie)

Claire and Sophie are two representatives of the women participants. Their experiences of going through the labouring process alone were shared by other women in the study. In the women's eyes, midwives are mainly task-focused, overlooking their needs for emotional and information support. The feelings of loneliness, being abandoned and disappointment again indicate the women's dissatisfaction with the service (see section 6.2.1.3). To cope with the midwives' reduced availability, women sought medical interventions as a way to mediate or terminate their 'suffering', as indicated below:

Most of the time midwives came to me was for injections or foetus monitoring ... the pain was killing me, but no one was there ... I felt really lonely ... I'd rather end this suffering by any means. So, I asked for surgery. (Woman, Sophie)

As Sophie said, when she spoke of the need for intervention during labour, she meant to seek support rather than confront the professionals.

Midwives commented that modern women were not demonstrating blind faith in the healthcare professionals but seeking a sense of control. However, the way women seek control is not always welcomed by the midwives. At this point, women's tendency to seek unnecessary obstetric interventions was identified as a challenge to the midwives, which placed them in a dilemma of being between their professional standards and the women's choice:

We know she was going through a tremendous event and she thought a caesarean can help terminate her suffering quickly. However, we also know there are many side effects of a caesarean. Also, her condition was fine, not included in the criterion for a caesarean. However, she insisted on surgery and so did her family. (Nurse-midwife, Fiona (TGH))

Convincing women of a normal birth means midwives needing to spend more time, which is evidently constrained by the organisational structure. The consumerist culture in healthcare services was claimed to increase the challenge (see section 6.2.2.3 'women's dissatisfaction with care') and occasionally intensify the contradiction of birth choices and turn it into disputes:

Nowadays, clients perceive themselves as consumers. As long as they pay for the service, we should provide them with perfect care, perfect outcomes ... but you know, no one can guarantee the perfect. (Direct-entry midwife, Ellen (TGH))

She was screaming and asking for a caesarean. I told her there was no sign for surgery. She said, 'My waters broke 24 hours ago. I can't stand the pain any more. I need surgery right now, or else you must be 100 per cent sure my baby will be okay!' [...] You hear the arguments outside [from the woman's family] ... demanding a caesarean. This is part of our work life ... reconciling disputes. (Nurse-midwife, Lena (TMH))

Even though the excerpts above are not a feature of all women, the sense of 'being responsible for the perfect outcome' can profoundly intensify midwives' views of childbirth as a potential risk. In the previous codes, midwives argued that their compromises when performing their work roles were subject to the authority of the medical paradigm. The above data suggest medical propaganda of the risk notion can undermine both midwives' and women's confidence in normal birth. It seems to expose midwives to a form of a vicious cycle; magnifying their risk concerns when advocating normal birth.

6.2.2.4 Risk Concerns

‘Risk concerns’ refer to the midwives’ stress when advocating normal birth under the medical demands of ‘reducing the risk’. It is related to the medical protocols, obstetricians’ dominance and women’s reliance on medicalised birth:

While different for the patients, pregnancy and labour is a normal physiological process for women. However, things are not always what we expect. There may be something wrong during childbirth. As a midwife, that’s the stress we work under. (Direct-entry midwife, Emily (TMH))

‘Things might go wrong’ is the common work stress underlying midwifery care that midwives frequently brought up during the interviews, which is associated with the uncontrollability underlying childbirth. The feeling of stress was particularly salient in the accounts of the less experienced midwives. Take Lena (a newly certified nurse midwife with three-year midwifery experience) for example:

Compared to the experienced midwives, I only have three years’ experience. I feel quite stressed during work. Every time, after work, I keep replaying every scene of my practice in my mind to see if everything I had done had no mistakes. (Nurse-midwife, Lena (TMH))

In terms of experience, midwives also attributed such work stress to their past adverse experiences, which is reflected in the account of ‘the more you have experienced, the more cautious you may become’:

I encountered one incident several years ago. At the time, the woman’s condition was quite normal. After ten hours’ labour, she started to give birth. During birth, however, a bad tearing happened. The woman and her family sued me for medical malpractice. This incident almost ruined my career. (Direct-entry midwife, Jessica (SH))

Although usually it won’t go to court, the poor outcome might cause lifelong suffering to us. We feel disgraced being criticised, judged. It can

crush our confidence and we may even lose our job. (Direct-entry midwife, Emma (TGH))

Midwives explained that the stress was increased by their consciousness of possible adverse consequences, particularly litigation. This was deemed a challenge for them in advocating normal childbirth. This challenge can turn into 'risk concerns' and arouse the feeling of uncertainty and even anxiety under the current organisational management.

In the previous discussions, the codes 'working under medical protocols', 'obstetrician is the leading professional' and 'women's reliance on medicalised birth' have provided evidence that medical power is playing a dominant role in defining what the appropriate midwife role should be. Midwives expressed their powerlessness under the medical model, as their professional ideals of advocating normal birth were suppressed by the medical propaganda of the notion that childbirth is a potential risk until the condition of the woman and baby is confirmed otherwise (Percival, 1970, Wagner, 1994). In terms of 'taking responsibility for any poor outcomes on our own' if not following the medical protocols, and the women's occasional confrontations for 'the perfect outcome', organisational focus of risk reduction has aggravated midwives' work stress and turned it into their concerns of the risk underlying their professional ideals of advocating normal birth. The resultant 'risk concerns' has the potential to render midwives risk-focused in practice, and consequently affects the construction of individual midwives' professional identity (see section 7.2 'compromising strategies').

6.3 Professional Discourse

The 'professional discourse' category explains the professional ideology underpinning midwifery practice, which forms another causal category determining the construction of professional identity in individual midwives. It is composed of two subcategories; 'being with woman' and 'advocating normal birth', representing how the ideological constructs central to the midwifery profession were employed by the midwife participants to define

their professional identity (see Figure 5). In the context of this study, although the majority of the midwives were prepared under the medical model and suffered role confusion, their commitment to these ideological constructs appeared to be developed and reinforced through a variety of professional development activities (e.g. initiating and participating in midwifery models of care, accessing international journals, attending midwifery conferences, exchanging knowledge with visiting midwives from other countries, clinical training in other units, and learning activities within their own units). These activities can be seen as the manner in which midwives tried to retain their professional identity by seeking their own professional development. However, as midwives were trained and prepared under a model that is mainly medical oriented ('medical preparation'), even though all midwife participants claimed the 'professional discourse' as the central tenet of their professional identity, some of them were not clear about the underlying meaning of it.

6.3.1 Being with Woman

'Being with woman' is a central concept for the midwifery profession originating from the definition of 'midwife' in old English. As an underpinning philosophy for midwifery practice, 'being with woman' has been espoused professionally and academically in global midwifery discourse (Kennedy, 2000, Hunter, 2002, ICM, 2011a). The use of 'being with woman' in this study focuses on its clinical aspects to explain how the midwife participants employed this ideological construct to define their professional identity in practice. 'Being with woman' was interpreted by the midwives as the caring role of being there to provide the continuous physiological, emotional and information care and support that is needed by the labouring woman. By bringing women into the centre of their practice, midwives tried to distance themselves from the task-oriented role that is assigned by the organisational management.

In the midwives' statements, women were viewed as the significant reference group which has the ability to determine the survival of the midwifery profession. The recognition from women serves as an important source for midwives to verify the value of being a

professional midwife. Sensing their invisible public image (see Section 5.2.3), midwives expressed their commitment to woman-centred care in an attempt to secure their professional identity and advocate midwifery profession, as Linda highlighted:

I told my staff midwives that they must bear in mind women are the root of our profession. Only when we put them in the centre of our service, can our value as a midwife can be recognised. (Direct-entry midwife, Linda (TGH))

It is reflected in both the midwives' need to establish a positive professional relationship with their clients and their individual beliefs of caring for women. As Anne said:

It is indispensable to our practice. If it is possible, I am more than willing to be there with women, helping them to go through the birth process, and provide them with as much support as possible. During that stage, they really need us to be there to support them. (Direct-entry midwife, Anne (SH))

By recalling her own birth experience, Mary further shed light on the importance of the 'humane services' in the midwifery care provision. She stated that service users in the same sense were women who were undergoing birth experiences akin to what she did. As such, they similarly need midwives' sincere presence:

I know the feeling of helplessness during labour. Women feel insecure, even scared, during childbirth, however they prepared for it. It is important, as a midwife, we give our time to them because their experience relies partly on how much time we have for them and how much we care for them, sometimes we may not necessarily do anything. Just be there. (Nurse-midwife, Mary (TMH))

Such commitment to being there for 'woman' was shared by the midwife participants, even for those without personal birth experiences. It implies that emotional and humanistic dimensions of midwifery care function as a source of intrinsic motivation for the midwives, forming the inner part of their professional identity.

As aforementioned, in hospital TGH one labour room is operated under an innovative midwifery model. Such a working context was viewed as creating opportunities for midwives to fulfil the 'being with woman' ideology in practice. In the following quote, Emma, who worked in this labour room, explained what being with woman meant in practice and how such practice facilitated her understanding of the meaning of being a professional midwife:

In this midwife-led care model, I've truly learned a lot. It emphasised continuous and woman-centred care. Midwives play a key role rather than the obstetricians. I got to experience the meaningfulness of my work, a feeling that I might never experience in an obstetric-led model. Like ... you know, I am responsible for the whole family. When I was there, in the labour room with the woman and her family, I felt what they were feeling, the expectation, the love and the pain. Likewise, I got their respect, trust and reliance on me ... feeling valued as being a midwife. (Direct-entry midwife, Emma (TGH))

Indicated in Emma's descriptions, the accomplishment of 'being with woman' has enabled mutual understanding and recognition between the midwife and the clients. While 'being with woman' can be connected to midwives' strategies in care provision, it is rather the principal value by which midwives present the professional self in interaction with their clients. These statements from midwife Anne, Mary and Emma, imply that despite working in different work settings, midwives are personally as well as professionally attached to this professional ideology.

More importantly, establishing mutual trust and understanding with women through being there for them was regarded as an important indicator to evaluate the success of being a professional midwife, even when childbirth was not proceeding as expected:

In the midwife-led labour room, the woman and her family knew we were there with them and witnessed what we had done. If something was wrong, and the caesarean or the instrumental delivery was needed, they were more considerate. (Direct-entry midwife, Catherine (TGH))

The significance of being with woman, and its positive effect on both the woman and the midwife were confirmed by the women participants. As Joanna recalled, the midwife's presence and continuous support was a source of reassurance to her during labour:

When the midwife kept me informed of progress, gave me the support and professional advice, I felt safe [...] To be honest, only after receiving care from them do I know who the midwife is. (Woman, Joanna)

Through the effective provision of information and support, the 'professional' image of a midwife seems more likely to be recognised by their clients. The positive feedback from the service users serves as an emotional reward and gives meaning to the midwives' practice. Such emotional rewards have the ability to motivate midwives to pursue their professional ideal and consequently affect the construction of individual midwives' professional identity (see Section 7.3).

6.3.2 Advocating Normal Birth

Professional boundaries have always been targets involved in the competition between professions. Midwifery is not an exception. In midwifery discourses internationally, it has been claimed midwives are the 'most appropriate professionals for childbearing women in keeping childbirth normal' in comparison to the medical professionals (ICM, 2008: 32). In this study, the subcategory 'advocating normal birth' explicates how the midwife participants used this ideological construct to establish the boundary with the medical professionals. By distancing themselves from the obstetricians' expertise area (complications), midwives tried to gain a better position in distinguishing them from the role of an obstetrician's assistant, regulated under the current organisational management.

6.3.2.1 What is Normal?

'Normal' standards of childbirth were brought up repeatedly in this study as the measure of a professional boundary between the midwives and the obstetricians. As a controversial

term in the literature of maternity care, there is no consensus of what exactly 'normal birth' means among midwife participants in this study. Rather, midwives used the term as a contrast construct to present their position in opposition to the medical focus of 'reducing the risk' in hospital settings.

In terms of the existing medical protocols, some midwives articulated their counterviews of the 'normal' standards defined by the medical model (as discussed in Section 6.2.2.1 'working under medical protocols'). As Juliet argued, if blindly following this medical standard, 'there might be no such thing as normal in the hospital':

I've read some papers in English [language] journals. I know midwives in many countries try more natural ways to help women, such as encouraging them to walk and changing position. I know if we were patient enough to wait and let women walk and move, the contractions would accelerate naturally. In our unit, however, everything is in a hurry. I have to say there might be no such thing as normal birth in hospital.
(Nurse-midwife, Juliet (TMH))

Likewise, as one of the co-ordinators to implement the midwife-led labour room in TGH, Catherine commented that the existent 'normal' standards were problematic. She challenged the scientific value of the standards and argued that 'they are outdated'. These midwives who were against the existing medical standards of 'normal' birth were identified as those who were able to access the evidence-based information through some professional development activities (such as Juliet and Catherine). For other midwives, they seemed to accept this timeframe uncritically as it has become the principle guideline in the textbook and hospital protocols (see Section 7.2.3).

Apart from the counterviews to the medical standards of 'normal', all midwives expressed concerns about the negative consequences that the overuse of medical interventions may cause to their practice, as well as to the women and the babies. Taking Fiona's metaphor of 'doping an athlete' for example:

Medical intervention, such as the commonly used induction, causes a lot of trouble to our work. In my experience, the foetus heartbeat usually changed abnormally if you artificially interfere in the labour. Figuratively speaking, the baby in labour and birth is like an athlete running to the finishing line. The athlete is supposed to keep the average speed, say 250 metres per minute, but we force him to speed up to 500 metres per minute. Similarly, inducing childbirth with drugs is somehow like illegal doping for the athlete. You see the consequence. Either he collapses halfway, or he finally arrives at the destination absolutely exhausted. It is very simple. Ironically, the overuse of the intervention has kind of become normal now. (Nurse-midwife, Fiona (TGH))

Based on their professional knowledge and experience, all midwives expressed their awareness that the existing high-level of medical interventions would do more harm than good to the health of the women and their babies. Such medical interventions, as midwives claimed, include the common use of oxytocin for induction and augmentation of labor, artificial rupture of the membrane and caesarean section. In terms of their own professional practice only the midwives in TGH, where the midwifery model was applied in one labour room, have articulated that episiotomy was not necessary to normal birth and made efforts to reduce the episiotomy rate. However, other midwives considered episiotomy as routine practice (see Section 7.2.3).

6.3.2.2 Professional in Normal Domain

Although in the workplace the role of the midwife is legitimately and hierarchically under the control of the obstetricians, ideologically midwives hold a counterview that they have the expertise in normal birth and are eligible to claim it as their professional domain. Inherited from the literal meaning of the title *zhù chǎn shì* (the modern midwife) in Chinese, midwives defined themselves as ‘the professional who assists normal childbirth’ (Nurse-midwife Maya SH) and ‘the professional who uses their expertise to help women get through birth as normally as it should be’ (Direct-entry midwife Catherine TGH).

Considering the 'nature' of midwifery care, midwives claimed that normal birth is their professional domain, as they are the professionals who possess specialist knowledge and skills to support normal birth. These specialist knowledge and skills were termed as 'expertise', which were acquired from their years of experience of working in midwifery care, as Ellen explained:

As a matter of fact, we master the specialist knowledge and skills in normal birth. Our expertise, such as observing the labour and birth, instructing women, providing women with sufficient support, baby delivery, were acquired from years of experience in assisting normal birth. (Direct-entry midwife, Ellen (TGH))

In the midwives' opinions, obstetricians have been trained to treat illness, and so complications are the best area for their expertise. Comparably speaking, with regard to experience, midwives claimed to be the leading professionals with knowledge and skills in normal childbirth. This self-perceived professional position in the 'normal' domain was expressed more explicitly by the midwives who had experience of playing a role akin to mentor for the novice obstetricians:

The newly qualified one [obstetrician] addresses us as a teacher, listens to and follows our instructions. (Direct-entry midwife, Anne (SH))

Many newly qualified obstetricians actually learned the skills of childbirth from us. Actually, even some of the experienced obstetricians do not have as many normal birth experiences as we do. Of course, they are trained to deal with the complicated cases. (Nurse-midwife, Juliet (TMH))

All the midwives in this study highlighted the clinical techniques and skills of assisting childbirth (such as labour and birth observation and baby delivery) as the essential midwifery expertise to buttress their professional position in 'normal' domains. Additionally, some midwives emphasised the non-medical interventionist care centred on psychosocial elements (as the value of being with woman discussed in section 6.3.1) to differentiate their

approach from the medical model supported by medical professionals. Take Jenny for example:

As for interventions, I say we use the psychosocial intervention. With years of midwifery experience, I believe effective communication, emotional support and empathy outweigh the purely obstetric techniques. I always tell the newly qualified midwives in my ward, 'It is common to feel scared of delivering babies, but it is absolutely unnecessary. Even if you do nothing, a baby can be born naturally'.... [Smiled]... It is true ...you know, two decades ago, all babies were born at home in the rural areas. (Direct-entry midwife, Jenny (SH))

With years of previous experience of working in rural areas, Jenny believed that childbirth is a natural process that women inherit the capacity to manage on their own. As a head midwife, Jenny shared her views of the 'normal birth' with her staff midwives and expected such 'normal' orientation to be carried on within the professional group.

To substantiate the role that midwives played in advocating normal birth, Emma shared a working story (quotes from her work journal) about how she successfully helped a woman to go through labour and birth in the midwife-led labour room:

This is great. I can see the baby's hair a bit. Though just a bit, it is progressing. Her husband was very excited: 'I see our baby's hair! Come on!' It was a touching moment. Though I knew it was just at the very beginning, I had big hopes for it ...

After a long-time of no progression ... her husband became anxious. He kept telling his wife, 'Dear, keep going, keep going. It is almost there. It will finish soon.' ... I should have suggested to him to not say 'soon' in such a situation. If you keep saying that when there was still no progress after trying many times, she would lose hope. ... Actually, it happened. [...] She told me 'I've tried my best. Now I am so tired. I can't do it. Please give me a caesarean.'

Yes, this is the hardest part in our work ... I tried to calm her down by encouraging her to 'take a breath, dear. See, it is promising. We've tried for quite a while, do not give up now. You can do it. Your baby needs you

to keep going.’ ... You know, while comforting them, I actually reassured myself. [...]

Wow, it is a miracle ... [Smile] ... I think it might be the ‘promising’ or the ‘baby’s calling’ that gave her the strength. She did it. ... When finally hearing the baby boy’s cry, the couple burst into tears. Yes, ... my work is part of a miracle. (Direct-entry midwife, Emma (TGH))

In Emma’s narrative, the typical features of midwifery care – the combination of stress and fulfilment – are manifested. As midwives talked of the category ‘risk concerns’, the labour and birth processes do not always keep on going as linearly as we expect. However, this is just where the value of midwifery care is reflected. Emma stated that when the natural process became sluggish, normally, it was caused by some psychosocial factors rather than pathological problems. As such, the legitimate intervention was supposed to provide women with the substantial support they needed, rather than to hastily provide medical interventions. The ‘miracle’ that Emma and the woman created is a sign of affirming Emma’s competence in the role of a professional midwife, which reinforced her own understanding of, and motivation for, advocating normal birth.

The above excerpts indicated that the midwives’ professional identity was continuously developed through working in the professional field. The experiences of working outside of hospital (e.g. Jenny), working in the midwifery model (e.g. Emma, Catherine), and of participating in other forms of professional development activities informed by midwifery discourse (e.g. Juliet), have contributed to the midwives’ counterviews to the medical model of childbirth, increased their competence in supporting normal birth, and concurrently facilitated their identification with the midwifery profession.

6.4 Identity Dissonance: The Obstetric Nurse Versus the Professional Midwife

To explain the source that determines the individual midwife’s professional identity construction in hospital settings two categories – ‘organisational management’ and

‘professional discourse’ – were analysed in this chapter. The analysis of the ‘organisational management’ category has demonstrated how the organisational structure of the hospital settings fashioned the midwives into the identity of an obstetric nurse through the practical demands of ‘focusing on the task’ and ‘reducing the risk’. The ‘professional discourse’ on the other hand has presented how the ideological constructs (‘being with woman’ and ‘advocating normal birth’) were employed by the midwives to define their professional identity in an attempt to distance them from the obstetric nurse identity under organisational control. These two categories of ‘organisational management’ and ‘professional discourse’ represent the conflicting ideologies that underlie hospital midwives’ practice, which demonstrate the interplay between the external definition and the internal definition of the midwife in hospital settings: the ‘obstetric nurse’ defined by the work organisation and the ‘professional midwife’ defined by the profession (see Figure 5). The characteristics of them are summarised as follows:

‘Obstetric nurse’ in this study refers to the midwife who is subject to the organisational categorisation of an obstetric nurse. These midwives’ work complies with the organisational management priorities of focusing on the task and reducing risk. What they perform are mainly technical roles rather than woman-centred care. They also rigidly follow the protocols and unwritten rules that are prescribed by the medical model, and their professional autonomy is largely limited under obstetricians’ supervision. Furthermore, under the management of the nursing profession, these midwives are more liable to accept the decisions made from the top down and express less desire to influence the decision-making process. As a consequence, these midwives are often detached from their women clients and are more likely to experience tension with the service users and dissatisfaction with their work, which in return undermines their commitment to care provision.

‘Professional midwife’ in this study refers to the midwife who keeps to the professional identification of an autonomous midwife. These midwives’ work priorities are in accordance with the professional ideology of being with woman and advocating normal birth. They work

in collaboration with obstetricians and are more flexible in their practice, and endeavoured to tailor the rules and conditions to meet women's needs. In addition, these midwives are more willing to seek opportunities for and actively engage in professional learning and activities, and are more involved in the decision-making regarding midwifery development. As a consequence, these midwives are more able to develop reciprocal relationships with their women clients and are more likely to gain recognition from the service users and satisfaction with their work, and in return are more committed to care provision.

In hospital settings, midwives were located in the intersection of the 'organisational management' and the 'professional discourse'. The interplay between these external and internal definitions of the midwife resulted in identity dissonance in the midwives, which has been analysed in Section (6.2.1.4) 'emotional distress' and Section (6.2.2.4) 'risk concerns'.

6.5 Discussion: Organisational Management and Professional Discourse

The preceding results embrace a clear sense of identity dissonance stemming from the contradictory ideologies underlying midwifery practice between the work organisation and the midwifery profession. It brings to mind Fahy's (1998) distinction of midwifery philosophy: 'doing' midwifery or 'being' a midwife. The 'organisational management', as midwives described in this study, is akin to Fahy's (1998: 11) presentation of 'doing', wherein the role of the midwife is focused on problem solving under 'techno-rational' approaches. The 'professional discourse', claimed by midwife participants as central to their professional identity, is analogous to Fahy's (1998) art of 'being'. Albeit reflecting the phenomenon in the context of China, the findings of this study support Fahy's (1998) concerns that the beliefs of 'being' can be demoralised if midwives are continuously required to focus on 'doing'. Midwife participants in the study reported that the work requirements of 'focusing on the task' and 'reducing the risk' left them less time and space to identify with the ideological constructs of 'being with woman' and 'advocating normal birth'. It indicates that midwives were kept in the workplace where the elements of 'being' a midwife was marginalised by the emphasis of 'doing'. Such a work role of the midwives has the potential to detract from appreciating the meaning of 'being', and in the long run it may fundamentally redefine the definition of the midwife with the role of the obstetric nurse.

In the following text, Lipsky's (1980) dilemma of the 'street-level bureaucrats' and 'cultural imperialism' in oppression theory (Young, 1988: 285) are referenced to situate the category 'organisational management' in the existing theories. The identity dissonance resulted from the contradictory ideologies underlying midwives' daily practice is discussed with reference to relevant literature in midwifery. Drawing on the studies on identity work, the way that midwives employed 'professional discourse' to construct and negotiate their professional identity is further discussed.

6.5.1 Organisational Management

6.5.1.1 The Dilemma of the ‘Street-level Bureaucrats’ (Lipsky, 1980)

The analysis of the subcategory ‘focusing on the task’ has revealed the bureaucratic management in the hospital settings and the structural power that the work organisations exerted over midwives through established policy, regulations and rules. As analysed in section 6.2.1.1 (‘midwife shortage at work’), midwives commented that the allocation of the midwife staffing in hospitals was primarily based on the organisational goal of clinical efficiency, while midwives’ professional ideal of being with woman was often overlooked at the expense of such organisational imperatives. As a consequence, the low resource allocation and high volume workload in midwifery services has confined midwives to a task oriented approach as analysed in section 6.2.1.2 (‘working on an assembly line’). Moreover, such organisational management also sheds light on the root cause for the tension between the midwives and women, as explained in section 6.2.1.3 (‘women’s dissatisfaction with care’). Consequently, midwifery practice in the hospital settings was bounded by the limited resources, heavy workload and increasingly difficult relationship with women. Midwives felt they were being placed in a constant dilemma between ‘focusing on the task’ – demanded by the service organisation in hospital settings, and ‘being with woman’ – valued by the service users and the profession. The maternity service organisation in the study hospitals can be attributed to market regulation in the current Chinese healthcare system, in which the hospitals were found to be driven by clinical efficiency and a profit motive (Blumenthal and Hsiao, 2005). Under such market principles, ‘being with woman’ was hardly considered as efficiently worthwhile in the service organisation.

Despite not explicitly addressing the notion of identity, Lipsky’s (1980) analysis of the dilemma of ‘the street-level bureaucrats’ enables understanding of the conflicting ideologies (‘focusing on the task’ and ‘being with woman’) underlying midwifery practice, which the

midwife participants faced when constructing their professional identity in hospital settings. Lipsky (1980) coined the term 'street-level bureaucracy' to explicate the structure of the modern public service organisation, in which the role of the service providers is often constrained by the organisational principle of processing clients in an efficient and effective way. Such organisational imperatives run counter to the nature of the service in that individualisation is needed both by the service users and the service providers (Lipsky, 1980). These service providers are termed as 'street-level bureaucrats' who frequently experience the dilemma derived from the service organisation in their workplaces, as the midwives did in this study.

The hospital-based midwives' practices, particularly in labour wards, seem to be universally constrained by such organisational management. In a meta-synthesis of 14 studies on the hospital-based midwives' experiences in five European countries, O'Connell and Downe (2009) found that a lack of freedom to exercise professional discretion was experienced by the midwives in all study sites, no matter how much autonomy the midwives in different countries were legitimately granted. Similarly, as revealed in the current study, the service organisation in these study hospitals was viewed as a major inhibitor preventing these hospital-based midwives from pursuing their professional ideal of being with woman to a varying degree. Additionally, the current study also found that the institutional position of Chinese midwives seemed to aggravate the situation (see Section 6.2.1.1). As the midwife participants claimed, the nature of midwifery care was not fully acknowledged by the nursing managers who supervised their practice, whilst the role of the midwife was almost viewed by the administration in the hospital settings as identical to that of an obstetric nurse. As a consequence, the significance of being with woman, the central concept underlying the philosophy of midwifery care, was often overlooked in the service organisation of the hospital settings.

6.5.1.2 Medical Culturalism

Discussion in Chapter Five has illuminated the marginalised position of Chinese midwifery at the institutional level, in which the structural power of the medical profession has played an important part. Findings in this chapter suggested that beyond the structural control, the medical profession also exerted its ideological power over the midwifery profession in practice via the prevailing use of the medical model in maternity care provision. 'Cultural imperialism', another feature of oppression (Young, 1988), was mirrored in the analysis of the category 'reducing the risk', which elaborates on how medicine exercised its ideological power to regulate the role of the midwife in hospital settings. According to Young's (1988) 'cultural imperialism', the findings in this study indicated that the medical profession functioned as a dominant group drawing on its medical norms to standardise and evaluate the work of the midwives. By the means of the medical protocols, the hierarchical stereotype of 'obstetrician is the leading professional' and the 'women's reliance on medicalised birth' – the notion of risk management central to the medical model was subtly instilled into midwifery practice.

As explained in section 6.2.2.1 ('working under medical protocols'), in the hospitals under study maternity care was mostly operated via the obstetric-led model (except one labour room in TGH which is operated under a midwifery model), under which 'Active Management of Labour' (AML) (O'Driscoll et al., 1993) was used as the principle guideline for maternity service organisation. Similarly, as commented on by many midwife participants in this study, AML has been criticised as a kind of assembly line (Kennedy, 1998), aiming at organisational efficiency (Hyde and Roche-Reid, 2004, Walsh, 2006), yet exercising power and control over women as well as midwives (Oakley et al., 1996, Murphy-Lawless, 1998). In terms of AML, some proponents argued that such management of childbirth can help to reduce caesarean sections and instrumental deliveries (Brown et al., 2008), whereas the opponents challenged that evidencing the effective ingredient of the package is the continuous companion rather than the strict medical monitoring and intervention (Thornton

and Lilford, 1994). In the study hospitals, however, this essential component of the continuous companion was missing (only one labour room in TGH allowed the presence of one birth companion and one midwife during childbirth), while the medical monitoring and intervention became the focal point of hospital protocols.

Amongst the components of the AML package, the 'normal time' limit of labour and birth is a central debate as it arguably enables medical dominance by determining the practice domain of midwifery in its medical term, as Mander and Reid (2002: 14) argued:

This redefinition of normality is but one example of the way in which not only practice, but also language has been manipulated in order to serve the ends of the dominant occupational group. (Mander and Reid, 2002)

The strict time threshold has been challenged as inappropriate for childbirth management (Albers et al., 1996) and in some countries, such as in the UK, has progressively become adaptable in practice (Purkis, 2006). In the current study, however, this normal time frame was written in the midwifery textbook and the subsequent use of medical interventions was dictated by the hospital protocols. By means of this medical standard of 'normal birth' and the hospital routines ('speeding up', 'the faster, the better') as midwives described, childbirth seems to be treated in the same way as a medical problem and accordingly the obstetricians' authority in childbirth is legitimised. As happened in many other countries, the study found that medical dominance has also increased women's reliance on medicalised birth (see section 6.2.2.3) by means of the widespread use of medical models and with support of popular media. Altogether, it may be safe to say that medical imperialism over midwifery in the study context has become substantial.

Such medical imperialism may go further to explain the organisational purpose under which hospitals constrained midwives through the practical demands of being risk focused. From the medical perspective, childbirth is viewed as a potential risk until the condition of the woman and baby is confirmed otherwise (Percival, 1970, Wagner, 1994), so that it is

deemed to be better managed by routinised and standardised risk control procedures (Van Teijlingen, 2005, Blaaka and Eri, 2008). In this sense, it is undoubtedly the existing medical model that is in favour with the administration of the hospitals, and through which the maternity service is easier to be structured for managerial purpose.

6.5.1.3 Identity Dissonance

Findings in this chapter have revealed that the hospital-based Chinese midwives' professional identity was constructed in relation to two competing identities: the external definition of the midwife ('obstetric nurse') that is bound up with the organisational management of focusing on the task and reducing the risk; and the internal definition of the midwife ('professional midwife') that is connected to the professional discourse of being with woman and advocating normal birth. The subjective discomfort with the conflicting ideologies underlying midwifery practice was evident in the findings (see section 6.2.1.4 'emotional distress' and section 6.2.2.4 'risk concerns'). The experience of discomfort derived from the co-existence of the conflicting beliefs was theorised by Festinger's (1957) concept of 'cognitive dissonance'. According to Festinger (1957), 'cognitive dissonance' is a state of psychological discomfort due to the coexistence of two or more inconsistent cognitions. For the midwives in this study, holding two competing identities is the cause of their cognitive dissonance.

The theory of cognitive dissonance has been widely researched by social psychologists, and the attitudinal and behavioural changes resulting from dissonance have been demonstrated and supported empirically (Cooper, 2007). Within the theoretical development, Aronson's (1968: 23) conception is probably most pertinent to cognitive dissonance in relation to identity:

At the very heart of dissonance theory, where it makes its strongest predictions, we are not dealing with just any two cognitions; rather we are usually dealing with the self-concept and cognitions about some

behaviour. If dissonance exists, it is because the individual's behaviour is inconsistent with his self-concept. (Aronson, 1968)

Aronson (1968) proposed that the strongest feelings of dissonance would derive from the contradiction between one's actions or decisions and one's sense of self-identity. When it comes to competing identities, several scholars have termed such experience of 'cognitive dissonance' as 'identity dissonance' (Costello, 2005: 28). In terms of the interplay between the external definition ('obstetric nurse') and the internal definition ('professional midwife') of the midwife in this study, midwives were suffering a general sense of emotional distress as the result of identity dissonance, such as frustration and disempowerment. There was also a classic sense of identity crisis (Costello, 2005) causing them to feel uncertain about their beliefs, values and commitment, as reflected in Sections (6.2.1.4 and 6.2.2.4).

- ***'Focusing on the Task' or 'Being with Woman'?***

Findings in this chapter have revealed that the midwives used the ideological construct 'being with woman' to define their professional identity. 'Being with woman' is a central concept that underpins the philosophy of midwifery practice (Hunter, 2002b: 650). In this study, midwives interpreted it as being there with woman, providing continuous physical, psychological and informational support, and assisting women through childbirth, which focused on the clinical aspects of the concept. This ideological construct ('being with woman') is viewed by all the midwife participants as the meaning that they ascribed to their professional identity, whilst they sought to verify this meaning through their actions and interactions in practice in order to identify with their professional group.

In identity theory, the continuous 'self-verification' of one's social identity is crucial for one's well-being (Burke and Stets, 2009: 232). Through the process of 'self-verification', individuals keep examining their behaviours or decisions with their identity standards. If there is a contradiction, the feeling of dissonance will be generated. As the dilemma that hospital-based midwives face in many other countries (O'Connell and Downe, 2009,

Rosenfeld and Foley, 2007), it is apparent in the current study that the professional ideal of 'being with woman' was often compromised to the work demand of 'focusing on the task' in the hospitals. A range of negative emotions emerged when midwives were unable to fulfil the meaning that they associated with their professional identity (see Section 6.2.1.4 'emotional distress'). It is consistent with the studies in relation to identity and emotion which indicate that identification with a group can generate emotional distress if the individuals fail to verify the identity standard connected to the group (Ashforth and Humphrey, 1993, Burke and Stets, 2009).

The process of 'self-verification' also involves individuals examining their own identity standards through the eyes of others who they interact with. They use this reflected feedback to evaluate their own perceptions of the self. If the reflected assessment matches their own identity standards, the 'self-verification' is confirmed, and individuals will have positive emotions (Stryker and Burke, 2000). Otherwise, if the 'self-verification' is interrupted, negative emotions appear (Stryker and Burke, 2000). Analysis of the category 'focusing on the task' in this study indicates that the existing organisational management constantly disrupted midwives' continuous verification of the ideological construct (being with woman) that they used to define their professional identity. The divergence between the professional ideal of being with woman and the work demands of focusing on the task thus generated a range of emotional reactions, particularly the feeling of frustration. This finding is in accordance with Hunter's (2004, 2005) study on emotional work of the hospital-based midwives in the UK. She found that the contradiction between the 'with woman ideal and with institution reality' left midwives in a state of frustration (Hunter, 2004: 268). In Hunter's study senior midwives were more likely to exercise the 'with institution' bureaucracy, while more junior midwives tried to advocate the 'with woman' approach, which gave rise to 'inter-collegial disharmony' (Hunter, 2005: 256). In the current study, there was no clear sign of the intragroup conflicts. The midwives attributed their task orientation to the bureaucratic hospital management. It is worth noting that, in the current study, some midwives implied that nursing management was in part responsible for the

enforcement of the organisational management of 'focusing on the task'. It suggests that it is problematic to incorporate midwifery into nursing groups and empower the nursing profession, which is viewed as not acknowledging the nature of midwifery, to oversee the midwives' practice. As a result, there seem to be fewer representatives at the managerial level to advocate midwifery care and the interests of the midwives.

In addition, it is important to note in the current study that the sound relationship with women worked as a source of intrinsic motivation for the midwives to engage in their practice and gave meaning to their professional sense of the self. When the midwives conceded to the organisational demands of 'focusing on the task', the positive relationship with women that can only be established through being with woman was compromised. The problematic relationship between the midwives and the women in this study was salient as this often happens to street-level bureaucrats-client relations (Lipsky, 1980). Being unable to fulfil the professional ideal of being with woman also prevented midwives from gaining the recognition from their women clients, who were viewed as an important source for midwives to verify the meaningfulness of being a midwife. In the terms of identity theory, the process of 'self-verification' is disrupted and negative emotions were generated as a result.

'Being with woman' is acknowledged as indispensable to midwifery care (Hunter, 2002). Many studies on intrapartum care have evidenced the significance of continuous emotional support and the caring role to the quality of care that midwives can bring to women e.g. (McCrea et al., 1998, Proctor, 1998, Kennedy, 2000, Gibbins and Thomson, 2001), and the potential exhaustion that the engagement of being with woman may cause to midwives (Kirkham, 1999). However, there is less research exploring how it will affect midwives' well-being if the ideological construct of their professional identity is unable to achieve. In the study on the stress and strain that Florida midwives experienced, Rosenfeld and Foley (2007: 2) revealed that constantly 'working against the self' can trigger midwives' feelings of 'burnout'. Findings in the current study are consistent with what Rosenfeld and Foley (2007)

found. In addition, the current study also suggests that the midwives sense of 'burnout' can be understood as a constellation of identity 'disconfirmation' from the management of their work organisation and in the eyes of their clients.

- ***'Reducing the Risk' or 'Advocating Normal Birth'?***

'Advocating normal birth' is another ideological construct that the midwives in this study employed to assert their professional identity. However, as revealed in the category 'reducing the risk', the fulfilment of this ideological construct was constantly oppressed by the medical model that is dominant in the current organisational management. To understand the midwives' identity dissonance in relation to the conflict between the organisational management of 'reducing the risk' and the professional pursuit for 'advocating normal childbirth', the jurisdictional boundary of medicine and midwifery – 'normal birth' – has always been the focus of debate (World Health Organization, 1997, Downe, 2006, Downe, 2004).

The domain consensus between medicine and midwifery seemed inevitably to be a problematic issue in the context of this study, as the parameters of 'normal childbirth' were exclusively defined by the medical profession. As reflected in section 6.2.2.1 'working under medical protocols', the power and control of the medical model is evident. Apart from the almost universal control that the ideological power of medicine exerts over midwifery practice in hospital settings (O'Connell and Downe, 2009), the current study also indicates that midwives' 'nurse' position at the institutional level further strengthened the obstetricians' leading position in the workplace. It was manifest in the policy documents in the healthcare system that midwives' 'autonomous' practice is under the conditions of medical professionals' supervision. Such institutionalised power of medicine resulted in a subordinate position of the midwives to the obstetricians in practice, as reflected in Section 6.2.2.2 'obstetrician is the leading professional'. Moreover, the study indicates that the ideological power of medicine has also been instilled in the public discourse, which

increased the women's reliance on medicalised births (see Section 6.2.2.3). By pursuing their professional ideal of advocating normal birth under such structural and ideological control of the medical profession, the midwives' feelings of identity crisis (Costello, 2005) are evident in the analysis of 'risk concerns' in Section 6.2.2.3.

The common concern of 'things might go wrong' in the current study has been referred to as 'intrinsic uncertainty' by Green (2006) and a 'grey area of practice' by Page (2010), as childbirth is viewed as a complex and chaotic event (Downe and McCourt, 2004) involving unpredictable physiological and psychological changes. Studies of uncertainty are often associated with the concept of risk (Page, 2010), as Beck (2009: 18) spoke of 'insurmountable uncertainty lurks in risk'. Specifically in clinical midwifery practice, uncertainty is liable to trigger emotional stress, which was categorised as 'anxiety' and 'concern' in Page's (2010) study. In the current study, when advocating normal birth for women, midwives' uncertainty was bound up with the concerns of poor outcomes and the consequences that may result. Such concerns are involved in the common emotional stress of uncertainty brought on by doubts about consequences, or their own abilities, as found by Page (2010) when exploring clinical uncertainty of midwives caring for lower risk labouring women in Scotland.

Apart from this, the study found that the 'risk concerns' were more related to the legislative guidelines and the protocols in the hospital settings, as discussed in Section 6.2.2.1 'working under medical protocols'. Midwives indicated that the consequences of not following the medical protocols may involve them in potential legal issues if adverse events happen, which caused their concerns about litigation and consequently holds them back from their identification with the role of normal birth advocates. As Cheung (2011) argued, the notion of risk is communicated by the legislative maternity service standards, which act for medical power to repress midwifery values by subjugating the practices of midwives to the medical system. The 'risk concerns' in this study related to the fear of litigation which is also considered as an impetus for midwives' compliance to hospital injunctions in the Porter et

al., (2007) study and by Page (2010). Though feeling more cautious in practice, Page (2010) found some UK midwives indeed enjoyed certain freedom to 'embrace the uncertainty', working towards their preferred approaches of care. Comparatively speaking, in the current study, midwives' feelings of powerlessness were strong when encountering medical protocols and medical agents. By being positioned in the nursing group, the midwives felt that their professional autonomy in advocating normal birth was greatly undermined in the interaction with the obstetricians, as discussed in Section 6.2.2.2 ('obstetrician is the leading professional'). Therefore, the 'risk concerns' can also be seen as a product of midwives' 'nurse' position in maternity care systems.

In addition, women's reliance on medical interventions (see Section 6.2.2.3) was revealed as another significant source of midwives' 'risk concerns' when advocating normal birth. The feeling of 'risk' is particularly salient in the situation when women confronted the midwives for the 'the perfect outcome' if they were not given caesareans. The findings are supported by an investigation of maternal request caesareans in South-East China (Zhang et al., 2008), and indicate that medical interventions have become common in Chinese maternity services, formulating public views of childbirth (Cheung, 2009). It implies that in the study context many features of modernism: the 'risk society' and resultant 'consumerist requirement for certainty and control' (O'Connell and Downe, 2009: 590) permeated midwives' everyday practice. However, it is also of concern that midwives' limited availability during labour was pointed out by the women participants as playing a part in aggravating their feelings of insecurity and subsequently prompting them to request medical intervention for a sense of certainty and control. Therefore, what Fleming (1998: 10) regarded as 'the potential for power to be abused by clients' is reflected in the consumerist pressure of asking midwives to guarantee the 'perfect outcome' in this study. However, such consumers' 'abuse of power' can be seen partly as a product of the current organisational management in the midwifery service, which served as another challenge for midwives to identify with the meaning that they associated with their group membership.

6.5.2 Professional Discourse

The institutional position of midwifery discussed in Chapter Five has suggested that this profession is in a state of marginality in relation to the professions of medicine and nursing. The marginal status of the midwives is reinforced at the organisational level, which is reflected in the analysis of 'midwife shortage at work' and 'obstetrician is the leading professional' in hospital settings in this chapter. Previous study has found that, with regard to the marginalised profession, resistance is identified as being a potential way to work on the oppressed identity (Dong and Temple, 2011). Resistance is manifested in a manner of deducting the dominant norms and fashioning the self in a favourable concept in an attempt to challenge the negative stereotype of their group (Dong and Temple, 2011). Being confined and subordinated by the organisational management of focusing on the task and reducing risk, midwives' resistance is manifested in the way that they drew on their central concepts ('being with woman' and 'advocating normal birth) in the 'professional discourse' to assert their professional identity in contrast to the subordinate image of the 'obstetric nurse' imposed by the maternity care system. Such use of ideological statements can be seen as a discursive practice, whereby the midwives dissociate themselves from the identity of the 'obstetric nurse'.

With a particular interest in the identity work that the midwives conducted to construct their professional identity in the contemporary maternity care system, the current study elaborates on the midwives' discursive negotiation with the 'obstetric nurse' identity that is bound up with organisational management. That is, midwives selected specific ideological statements to construct their collective professional identity for the contextual purpose:

on one hand, the emphasis of 'being with woman' can be seen as a form of discursive identity work that the midwives attempted to legitimate their professional identity by positioning women at the centre of their midwifery rhetoric. As well as employing this midwifery ideal to compare with obstetric practice, as identified in Rosenfeld and Foley's

(2007) study, the use of 'being with woman' in the current study more specifically fills the service gap that the task-oriented role in the organisational management caused, as the midwives perceived this intrinsic element of their professional identity (being with woman) to be missing in busy hospital settings.

On the other hand, with the reference to 'advocating normal birth', the midwives intended to establish an 'occupational demarcation' with the medical profession in order to present the self in an equal position to obstetricians. The 'occupational demarcation' as suggested by Allen (2000: 343) could be interpreted as 'micro-political strategies through which work identities and occupational margin are negotiated'. Normality and normal birth has been a central but problematic term in defining the occupation demarcation between midwifery and obstetrics (World Health Organization, 1997, Downe, 2006, Downe, 2004). This study is no exception. Rather than trying to define what is normal, the midwives used the ideology of 'advocating normal birth' as a contrast construct to the existing management of medical model, in order to dis-identify themselves with the risk-focused role imposed by the work organisation, and in turn to avoid being positioned as an obstetric nurse. The way of using medical discourse to legitimate midwives' own position as professionals has been similarly reported by Foley and Fairclough's (2003) study on Florida midwives and Pollard's (2011) study in an English maternity care unit.

According to social identity theory, in order to construct a social identity, the process of group categorisation is always involved, by which in-group members form a symbolic boundary to differentiate themselves from the out-group and enhance their self-image (Riesch, 2010). In an attempt to explain the boundaries amongst different professions, Abbott (1988) proposed the concept of 'jurisdictional boundaries'. The dynamic nature of the jurisdiction was also acknowledged, which, he suggested, can be claimed and negotiated (Abbott, 1988, Purkis, 2006). The negotiation of 'jurisdictional boundaries' was referred to as 'boundary work' by Gieryn (1983, 1999) in his study, whereby scientists distinguished their public image from the non-scientists through a range of discursive activities, including

the verbal or textual presentations of the profession. Similarly, discursive boundary work is evident in the 'professional discourse' category of this study. Midwives have employed a set of selected characteristics ('being with woman' and 'advocating normal birth') of the group to construct a symbolic boundary in order to preserve their valued professional identity.

The manner of employing identity constructs as an 'underlying interpretive framework' to create differences from other groups was also revealed in Scoggin's (1996: 38) study on how the American nurse-midwives defined themselves in relation to midwifery, medicine and nursing (see Chapter Two). Scoggin (1996: 38) found that the nurse-midwives used the traditional ideology of midwifery ('advocacy, normalcy, competency, authority and autonomy') to define their professional identity in order to differentiate themselves from medicine and nursing. Although the ideological constructs (being with woman and advocating normal birth) that midwives employed to define their professional identity in this study is not identical with what the midwives in Scoggin's (1996: 38) study employed, it can be understood that the selection of the identity constructs may depend on how best they can help achieve the demarcation between midwifery and other groups. In addition to identifying the meaning associated with midwives' professional identity, the findings of the current study have furthered Scoggin's (1996) study by detailing how the nurse-midwives used those ideological statements to negotiate and defend their professional identity in relation to the obstetric nurse identity assigned by the maternity care system.

As an adaptation of 'identity work' (classically referring to the individual-level identity management), midwives' collective sense of identification with the profession (collective identity work) is evident in this thesis. The theoretical perspective in identity politics (discussed in Chapter Two), particularly Castells' (2004) interpretation of identity, has given theoretical insights into this collective sense of identity work. The 'legitimising identity' (Castells, 2004: 8) is reflected in the categories 'institutional position' and 'organisational management' in this study, which demonstrate how the maternity care system legitimised the identity of 'obstetric nurse' to the midwives through the institutional imperatives and

service organisation in hospital settings. 'Resistance identity' (Castells, 2004: 8) on the other hand is manifested in the category 'professional discourse' in that midwives drew on the relevant ideological constructs to define themselves as 'professional midwives' in order to resist their nurse identity. Such collective identity work represents midwives' discursive practices of resisting their 'legitimising identity' in an attempt to attain and retain their membership of the midwifery group.

6.6 Conclusion: Conflicting Ideologies underlying Midwifery Practice and Identity Dissonance

The preceding discussion has elaborated on the contradictory ideologies underlying midwifery practice that determined the midwives' professional identity construction, the identity dissonance it resulted in, and the discursive identity work that the midwives used to construct and negotiate their collective professional identity within the current organisational management. The two principle categories 'organisational management' and 'professional discourse' in this chapter have built upon each other to demonstrate the interplay between the external definition and the internal definition of the midwife in hospital settings: the 'obstetric nurse' and the 'professional midwife'. The analysis of the two principle categories has revealed that the hospital-based midwives were located in their profession as well as the work organisations, and thus had to work on the competing identities defined between the two communities. Although the study indicated that midwives discursively identified themselves with the midwifery profession by drawing on the relevant ideological constructs, there is in fact a gap between the professional and theoretical discourses with actual practice. In practice these identity constructs were enacted differently by individual midwives. In the following chapter, how individual midwives construct their professional identity in hospital settings is examined through the action/interaction strategies they employed in response to the identity dissonance between the 'obstetric nurse' and 'professional midwife'.

CHAPTER SEVEN: ACTION/INTERACTION STRATEGIES AND CONSEQUENCE – COMPROMISING OR ENGAGING AND HYBRID IDENTITY

7.1 Introduction

The analysis of categories in the previous two findings chapters has demonstrated the contextual and causal conditions of the midwives' professional identity construction. The principle category of 'institutional position' analysed in Chapter Five has depicted the marginalised status of the midwifery profession in the current maternity care system, which contextualised the construction of the professional identity in midwives. The two principle categories 'organisational management' and 'professional discourse' analysed in Chapter Six have explicated the two conflicting ideologies underlying midwifery practice, which demonstrated the interplay between the external definition ('obstetric nurse') and the internal definition ('professional midwife') of the midwife in hospital settings and the identity dissonance that the competing identities resulted in. This chapter now sets out to elaborate on how individual midwives constructed their professional identity in hospital settings through examining the action/interaction strategies that the individuals used to reconcile the identity dissonance in practice (see Figure 6). Two types of strategies were identified by the midwives for this purpose: 'compromising strategies' (concessions made to organisational management) and 'engaging strategies' (engagement in professional discourse). As the consequence of the action/interaction strategies, a 'hybrid identity' emerged as the individuals' professional identity construction appeared to be navigated on an identity continuum with the external definition 'obstetric nurse' and the Internal definition 'professional midwife' at either end (see Figure 6,7). With reference to the relevant literature, the findings are discussed at the end of this chapter.

Figure 6: Table - Action/Interaction Strategies and Consequence – Compromising or Engaging and Hybrid Identity

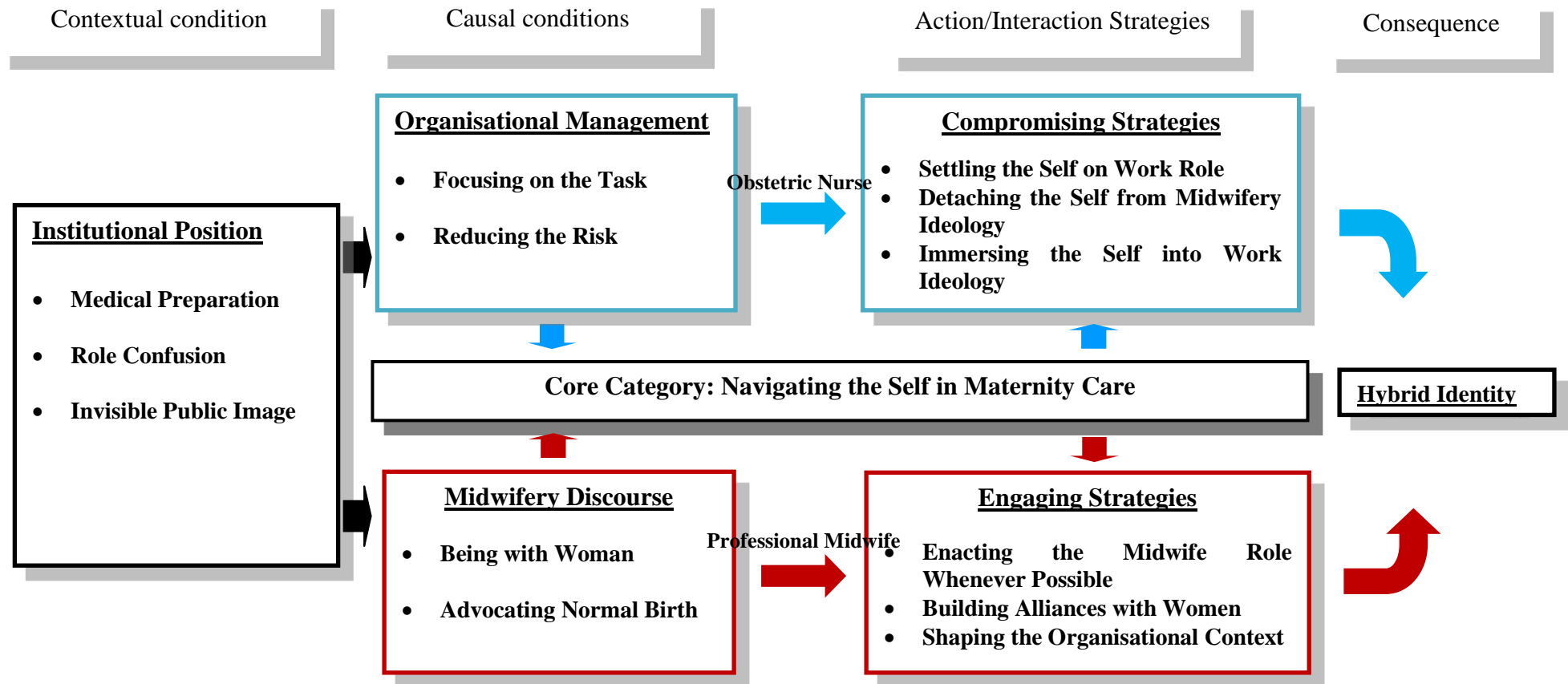
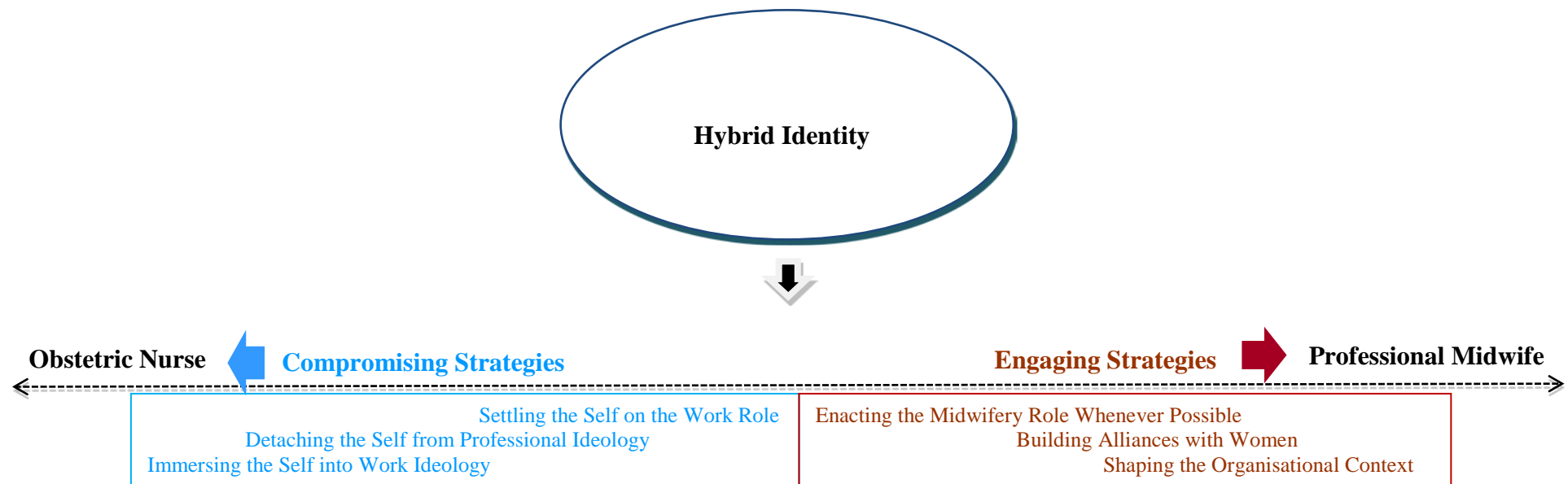


Figure 7: Diagram - Action/Interaction Strategies and Consequence – Compromising or Engaging and Hybrid Identity



7.2 Compromising Strategies

Analysis in Chapter Six has revealed midwives' identity dissonance in hospital settings, which is derived from the conflicting ideologies in midwifery practice between 'organisational management' and 'professional discourse'. On the one hand, a range of 'emotional distress' was generated because the existing organisational management confined midwives to a task-oriented approach to care that contradicts the identity construct (being with woman) midwives attached to their professional identity. On the other hand, 'risk concerns' in relation to advocating normal birth were developed in the central narratives of midwifery practice, as the very meaning central to the midwives' professional identity (advocating normal birth) was repressed by the medical model under current organisational management. In order to reconcile the identity dissonance, one type of coping strategy that midwives employed was to attempt a compromise in relation to organisational management. By adopting the following strategies; 'settling the self on the work role', 'detaching the self from professional ideology' and 'immersing the self into work role', midwives have made concessions to the external definition of the midwife ('obstetric nurse') to varying degrees (see Figure 7).

7.2.1 Settling the Self on the Work Role

Firstly, settling the self on the work role whilst leaving professional ideology aside for the moment is the common strategy that midwives have adopted. Midwives usually chose to focus on the technical tasks or acquiesce in the medical protocols when their professional ideology was repressed by the practical demands or medical power of the maternity care institution.

Midwife participants commented that their juggling responsibilities and tasks overload in hospital settings made it hard for them to be fully present for individual women and to engage in their childbirths thoroughly. Generally, they worked at completion of the 'basic

technical tasks', primarily concerning the 'physical safety of mothers and babies' (Nurse-midwife Juliet TMH), in order to deliver the average service to each woman, as Mary brought up:

I understand every woman is the individual. She has her own expectations and needs us to be there with her. The reality is, in the busy hospital, we have more than just one woman to take care of and can't be there for one person all the time. So what we can do is to focus on the task and deliver the service equally to all. (Nurse-midwife, Mary (TMH))

Mary's compliance with the universalised care provision reflects her attempts to settle on the technical tasks of their work role, whilst leaving the ideology of being with woman aside for the time being. Such compromise strategy has echoes of Lipsky's (1980) analysis of the street-level bureaucrats when managing their often heavy workload. Under the limited resources and practical constraints, the common strategy that front-line public service providers adopt is to exercise their constrained discretion to attempt an equal service to all clients: for midwife participants in this study this means having to practise against their professional values at times; in this case, by complying with the universalised care of the organisational mandates rather than the individualised care central to their professional discourse.

Midwives in the study also concurrently claimed to be professionals who advocated normal birth. However, data suggested that the midwifery service was located in the system where childbirth was bound up with the culture of risk and medical power. Midwives' everyday practices were regulated by medical protocols. If these were by any means broken, they would 'be responsible for the adverse event' (Nurse-midwife Juliet TMH). In an attempt to offset the work stress in relation to the 'risk concerns' of potential litigation, the action that midwives often undertook was to acquiesce into the medical protocols whilst leaving the ideology of advocating normal birth aside temporarily. As Juliet commented:

However, in hospital many of our practices focus on avoiding the potential risk of the poor outcome, like giving interventions beforehand. I know some of them [interventions] are unnecessary. However, we must follow them, as long as woman and baby are safe. It is a kind of unwritten rule. We need to follow. (Nurse-midwife Juliet (TMH))

Juliet indicated that the 'woman and baby are safe' is the bottom line. That is, as long as the woman and her baby are physically safe, other things such as interventions being necessary can be tolerated. In this sense, the political and legal power of the medical system seems to stimulate midwives to practise defensively by following the medical rules to play it safe.

For some midwives like Juliet, they felt quite reluctant to take on the medical rules, because their orientation of keeping women from unnecessary interventions may require taking risk upon themselves. However, for the less experienced midwives, like Yvonne (a newly certified nurse-midwife with three years of midwifery experience), the decision of whether to comply with the medical protocols seems to be on a more voluntary basis:

Our head [midwife] encourages us to keep childbirth as normal as possible. However, compared to other experienced midwives, I only have three years' experience in labour wards. I am not confident about my skills so far. Take episiotomies for example, I personally prefer to use them as a safety precaution. If I cause a third degree tear, women will suffer more and I might be at the centre of a medical dispute as well. (Nurse-midwife, Yvonne (TGH))

As mentioned by the midwives, the unwritten rule of instigating interventions at an early stage and the routinised technical interventions (such as episiotomy) was strengthened by the potential threat of a medical dispute. For the less experienced midwives, they perceived that they were less competent in advocating normal childbirth. The choice of an intervention was deemed a defensive practice in the belief that this can minimise the risk of medical malpractice as well as ensure the safety of the woman and baby (Aslam, 1999). Under the stress of birth-related 'risk', the focus of the medical protocols with certain routine interventions seems to offer these midwives some relief, particularly in situations

that they feel less competent at managing. They thus chose to follow the medical model of childbirth with the purpose of physical safety of the mother and baby.

7.2.2 Detaching the Self from Professional Ideology

Secondly, detaching the self from professional ideology for self-protection was another strategy that some midwives adopted in an attempt to reconcile their work stress in terms of 'emotional distress' and 'risk concerns' related to the relationship with women clients. These midwives chose to disengage themselves from the caring role or hand over their responsibility to the obstetricians.

As indicated above in Mary's words, midwives commented that their everyday work was caught in the middle of the organisational demands for task focus and the women's expectation of individualised care provision. When midwifery care focused mainly on technical aspects, women's individualised needs were compromised. Tension between midwives and women was consequently generated. As identified in section 6.2.1.4 'emotional distress' in Chapter Six, midwives' sense of 'burnout' can be evoked by the accumulation of the heavy workload and the tense relationship with women. It has the potential to affect midwives' professional commitment, pushing them emotionally away from women, as Ellen expressed:

In the past, I cared for them, their feelings and their pain. I comforted them sometimes, like talking to a child ... explained the normal processes ... helped them to go through it ... but now, women are becoming less understanding and I don't have enough time either ... I am not as caring as I used to be ... it [caring] is quite draining. (Direct-entry midwife, Ellen (TGH))

For midwives like Ellen, the choice of caring less is another type of compromise, by which they attempted to protect themselves from being drained by their emotional attachments. In so doing, these midwives chose to disengage themselves from the caring role and emotional support at work; the valued aspects of their professional identity. Additionally, in

comparison with her previous work performance, Ellen's words also highlighted the impacts that the existing organisational management and the relationship with women have upon the construction of the midwives' professional identity. Her changing attitudes towards midwifery care also reflect the dynamic nature of the professional identity construction.

With regard to the 'risk concerns', many midwives like Emily (Direct-entry midwife TMH), chose to consult with the obstetricians to make an optimal care plan for women. Others (like Maya Nurse-midwife SH) felt reassured having obstetricians around when she was assisting childbirth. These midwives valued such choices as being able to share the responsibility with obstetricians. However, some midwives suggested under the pressure of women's reliance on medicalised childbirth, sometimes they may go further and intend to give up their responsibilities to the obstetricians, as Anne indicated:

The risk is high in the obstetric unit. The dispute with service users happens quite often here. Some women are hard to communicate with now. When labour starts, they scream for a caesarean. If not, we must promise to guarantee the health of them and their baby. In cases like this, we usually ask obstetricians to talk to them. If the obstetricians agree to give surgery, we prioritise the obstetricians' decision ... as in the hospital, obstetricians manage childbirth. Our care is mainly based on their orders. (Nurse-midwife, Anne (SH))

Findings in the previous two chapters have revealed that at the institutional level obstetricians were authorised by health-care policy to supervise midwives' work and were legitimately involved in all women's childbirths. In the organisational hierarchy, midwives felt they were being positioned as obstetricians' assistants in terms of decision making. Regarding the political power of the obstetricians, midwives' subordinate position seemed to be imposed from the top down. However, in practice the 'risk concerns' pertaining to the potential legal dispute from the service users have at times triggered a midwife's choice of self-protection. In order to relieve the risk concerns originated from the consumerist confrontation for 'the perfect outcome', these midwives have detached themselves from advocating normal birth by handing over responsibility to the obstetricians.

7.2.3 Immersing the Self into Work Ideology

Another strategy that midwives employed was to allow themselves to be immersed into the work role without consciously feeling identity dissonance. These midwives took on the role of 'doula midwife', or took in the medical views unconsciously.

In the study hospitals (TMH and SH), as a way to bridge the aforementioned service gap for managerial purposes, midwife managers initiated a 'doula programme' to compensate for the shortage of midwifery staffing in wards:

In consideration of our heavy workload, at the moment we hire doulas to provide one-to-one care instead. (Direct-entry midwife, Emily (TMH))

Recently, because of our heavy workload, there are worries that we can't meet the needs of risk management. We apply the doula programme to deal with such situations. (Direct-entry midwife, Jessica (SH))

Midwives described the doulas providing services during childbirth, acting as an emotional supporter and a primary care provider to labouring women, and a messenger to the women's families who wait outside the labour ward. Since the doulas' accessibility and constant availability gave women a sense of reassurance, saved midwives' time for the routine work and subsequently helped to resolve potential disputes, this service was accepted by the staff midwives, as indicated in Juliet's words:

A doula will come to accompany a woman when she is 2.5 centimetres dilated until two hours after birth. In particular during the night shift with short staffing, doulas' availability is a reassurance to the woman and her family waiting outside. Certainly, we have time to finish our technical work. Many disputes happened just because we don't have enough time to communicate with the family. If we can inform the family of progress every half an hour or an hour, they feel relieved. (Nurse-midwife, Juliet (TMH2))

Either the midwife managers' support or the staff midwives' acceptance of doula programmes indicate midwives' inclination to hand over the caring role to doulas.

As introduced in Chapter Two, there were two group practitioners who provided a doula service; labour delivery room obstetric nurses and midwives, either employed or retired. However, in the study hospitals, the on-the-job midwives were the main resource for doula service provision. In hospital THM, half of the doula services were provided by the on-the-job midwives in the unit when they were off duty, while in hospital SH all were done by the on-the-job midwives. The on-the-job midwives, who take on the doulas' role, are named as 'doula midwives' (Cheung et al., 2005), who provide doula services to the women who are willing to pay extra money:

The doula work is conducted by the on-the-job midwives in our units and the retired midwives. Women choose whether to hire a doula or not on a voluntary basis. Since, in our unit family members do not stay with the women during labour and birth, some women with better economic conditions prefer to hire one ... Yes, they need to pay extra money for the doula service and this fee is out-of-pocket costs not included in the maternity insurance. (Nurse-midwife, Lena (TMH4))

Not every woman can access the doula service. They may require one, but need to pay extra money for the service. In our unit, just on the-job midwives do the doula job. If we are too busy, we can't do it, only when we have time. (Direct-entry midwife, Anne (SH4))

From the managerial standpoint, doulas can be seen as an ideal substitute for the caring role of the midwife because it can relieve the organisation from pressure of midwife staffing shortages, whilst some costs of midwifery care are passed on at the clients' own expense. However, from the professional perspective, the application of doula services has the potential to undermine the role of the midwife, because what midwives declared as their core value has become an extra service beyond their practice scope.

Additionally, for the 'doula midwives', sometimes, when the wards were too busy, they retrieved the role of the on-duty midwife, simultaneously providing doula services, giving professional advice, and assisting childbirth. In such a situation, midwives felt they were actually more able to enact their professional ideology of being with woman, which was

often constrained on their normal midwife shift. Such role switching from one to another is likely to confuse midwives about what it means to be a midwife, because what they perceived as central to their professional self can only be achieved when being hired as a private 'doula midwife'. It is indicated in Maya's words below:

I think doulas' work is more about the one-to-one care, so I won't be distracted by other tasks of caring for other women. When I don't do doula work, it means I am responsible for other tasks as well. So, I cannot spend much time on only one woman. For me, I think there is no difference [between working as a doula midwife and working as a midwife]. If I have time, I can be there with her for one-to-one care. For me, the difference is just one-to-one care or not. (Nurse-midwife, Maya (SH))

Maya's words indicate that other than the role confusion caused by their institutional nursing position (discussed in Chapter Four), in practice some of the midwives' identity was also mixed up with the role of the doula. More worryingly, if the on-the-job midwives continued taking on and integrating the role of the doula-midwife, they would be in danger of losing their internal definition of the midwife - a professional midwife.

In the medical view, childbirth is commonly considered as a potential risk until the condition of the woman and baby is confirmed otherwise (Percival, 1970, Wagner, 1994). Analysis of 'working under medical protocols' in Section 6.2.2.1 has revealed that such medical views have played a dominant part in defining what the appropriate midwife's role should be. Being trained and working under the medical model, some midwives seemed to take in such medical views without consciously feeling the conflict. Taking Mary's account for example:

In my opinion, it is almost impossible to have non-interventional childbirth. From my experience, I feel the average of the labour process just becomes abnormal, either too fast or too slow [according to the 'normal' time frame of childbirth]. Only a few women give birth normally. (Nurse-midwife, Mary (TMH))

By conforming to the medical standards of 'normal' birth, midwives like Mary were apt to apply such medical views to their practice. They employed the medical standard of 'normal' to observe, evaluate and monitor the condition of childbirth. As a result, they were less likely to accept the variations involved in this normal physiological process. Mary's words echoed what Mead (2004) has found; if immersed in such medical views, midwives would anticipate lower rates of normal birth than actually were the case.

Unconsciously taking in the medical views was more evident in the analysis of 'medical preparation' in Section 5.2.1 and 'role confusion' in Section 5.2.2. Although all midwives viewed the ideological construct (advocating normal birth) central to their professional identity, some of them were not clear about the underlying meaning of it. Therefore, many midwives attempted to reclaim the title of 'midwife' by asserting that they had certain control over their work in comparison to nurses, much of their self-perceived professional autonomy relies on medical standards of 'normal' birth and its subsequent practice guidelines. Taking Emily's descriptions of her daily work for example:

What we practise is based on hospital protocols. We observe the labour course. If the process of labour is going smoothly ... there is no symptom of foetal distress, cephalopelvic disproportion, prolonged labour etc, ... we work on our own, attending childbirth, delivering babies, including episiotomy. In this way, we have greater autonomy compared to nurses. (Direct-entry midwife, Emily (TMH))

Seeing the title 'nurse' as a symbol of the degradation of their professional status, some midwives, like Emily, have adopted the medical orientation to demonstrate their autonomy in practice in comparison to nurses. It reflects the interactional nature of identity (Stryker and Burke, 2000), as the midwives presented a 'medical' face in the situations where they attempted to distance themselves from the 'nurse' position that is given by maternity care institutions. In so doing, these midwives have appeared to attach themselves to the medical model, make clinical judgements and take actions on the basis of medical protocols. Such unconscious compromise, which these midwives made with the medical model, has in effect

enhanced the power of the obstetricians whilst ingrained the position of the midwives as the obstetricians' assistants.

7.3 Engaging Strategies

In the context of this study, data revealed that midwifery discourse has been gradually instilled into midwives' practice through a series of professional development activities (e.g. initiating and participating in midwifery models of care, accessing international journals, attending midwifery conferences, exchanging knowledge with visiting midwives from other countries, clinical training in other units and learning activities within their own units: see Section 6.3). These activities can be seen as the way that midwives negotiate with the maternity care institution by pursuing their own professional development. Midwives' efforts to gain midwifery knowledge and experience through professional development activities have in return created a possibility for them to apply 'professional discourse' in practice, furthering their sense of belonging to the professional group.

It represented an alternative type of coping strategies that midwives employed to manage identity dissonance: engagement in profession discourse. By adopting the following strategies: 'enacting the midwife role whenever possible', 'building alliances with women' and 'shaping the organisational context', midwives have engaged in identifying with their internal definition ('professional midwife') to varying degrees (see Figure 7).

7.3.1 Enacting the Midwife Role Whenever Possible

Firstly, enacting the midwife role whenever it is possible was the common strategy that midwives employed to fulfil their professional discourse in practice. Such an engagement strategy was often used by the midwives who had chosen to settle on the work role for the moment under organisational control. When it is possible, these midwives would try to

make best of the organisational resources or eschew the medical protocols to pursue the role of professional midwife.

Analysis of 'being with woman' in Section 6.3.1 has shown that the emotional and humanistic dimensions of midwifery care were an integral aspect of midwives' professional identity, whilst women's satisfaction with and recognition of midwifery care was where the value of the midwife was manifested. Many midwives in this study have developed a strong attachment to the 'with woman' ideology. While the need to be with woman seemed draining under the current organisational management, making the best of the existing resources in care provision was the common action that midwives have taken. Other than employing a doula to fill the service gap, these midwives assigned midwife students or on-the-job-training midwives to provide continuous support to the women they cared for:

I have been trying to provide women with sufficient support. However, it depends on how busy I am. If I was quite busy and couldn't give her continuous care, I would try to arrange someone to be there with her, a midwife student or an on-the-job-training midwife. The principle is that if it is possible, we will do our best. (Nurse-midwife, Mary (TMH))

In the analysis of 'settling the self on the work role' in Section 7.2.1, Mary indicated that her compromise strategy was an attempt to pragmatically balance the organisational management and the care needs of the individual woman. Such compromise was considered not as purely giving up the ideology of being with woman, but rather a strategy to leave it aside for the moment. In this sense, Mary's engagement in being with woman came to be evident in the above statement, which reflects the dynamic nature of the construction of midwives' professional identity.

With the support of midwifery discourse, midwives were equipping themselves with the normal birth knowledge and experiences, which helped to enhance their beliefs and competence in advocating normal birth. The study revealed that the midwives, who were competent in their midwifery knowledge and skills, were more likely to make an effort to

sustain their normal orientation. These midwives were identified as those who have years' experience of working independently in the maternity service; like Jenny who has been working in a rural health centre for ten years, and those who have practised in the workplace influenced by the midwifery model, such as Daisy. However, bearing in mind the current dominant power of the medical model, these midwives chose to circumvent a confrontation with this paradigm; rather they have sought to eschew the medical protocols:

Sometimes, I find I can keep things normal, when obstetricians are quite busy, especially during the night shift. (Direct-entry midwife, Jenny (SH))

If we want to play a midwife's role to keep things normal, the midwife-led room is a better place to work. Normally, we can keep the obstetricians away from there. (Direct-entry midwife, Daisy (TGH))

As part of the medical system, these midwives decided not to confront medical power and challenge the authoritative obstetricians directly. They sought to perform their professional role fully on the night shift and to keep the obstetricians away. Similar forms of practice employed by the hospital midwives in the UK were known as 'doing good by stealth'; by which these midwives aimed to deal with the oppressed intra-group culture (Kirkham, 1999: 736). Kirkham (1999: 735) revealed that the culture of midwifery in the National Health Service in England was permeated with 'service and sacrifice' wherein midwives lacked support and positive role modelling within the group. With the pressure to conform in such a culture, one possible way for change was identified as achieving objectives in a 'surreptitious behaviour' (Kirkham, 1999: 736). Other than coping with the oppressed culture within the midwifery group as these UK midwives did, midwives in this study used such devious strategies to achieve their professional goal (advocating normal birth) under medical dominance.

7.3.2 Building Alliances with Women

Analysis of the 'invisible public image' in Section 5.2.3 and 'being with woman' in Section 6.3.1 in the previous two findings chapters have revealed women's support was of significance in sustaining midwives' professional identity and midwifery profession. Making alliances with women in care provision was another strategy that midwives used in order to engage in their professional ideology. Successfully allying with women clients has enabled midwives to better negotiate with the organisational management.

As a way to negotiate with the medical protocols, most midwives have tended to empower women by taking every opportunity to keep women informed about the negative effects of medical interventions, as Yvonne did:

I saw the women with medical induction feel much more pain than in normal labour, because the body is not ready ... they are more likely to ask for a caesarean during labour ... So when I cared for the women, I tried to remind them of the outcome, like 'you need to think thoroughly, induced labour will become very painful later. (Nurse-midwife, Yvonne (TGH))

Giving women informed choices was an example of midwives' attempts to build up alliances with women in order to facilitate normal birth. Additionally, the application of the midwife-led labour room was a more explicit example of such attempts.

In hospital TGH, there is a midwife-led labour room in operation, wherein midwives have obtained opportunities to enact their professional discourse of being with woman and advocating normal birth. By these means, midwives have built alliances with women, who have enabled them to better negotiate care with the medical protocols and the obstetricians. Taking Emma's experience (quotes from her work journal) as an example:

I worked with her and explained every move of her birth with a pelvis model. 'You are in the latent phase, so the dilation is a bit slow ... Now, it

is the active phase, it will become faster ... Yes, eight centimetre dilated now ... your baby's head is descending'. 'Oh, so it is.' See, while explaining every detail to her, I helped her to trust her own body. When the obstetrician showed up and planned to give her oxytocin, she asked for more time. It encouraged me to work with her ... She worked it out. I felt so fulfilled, and proud to be a midwife. (Direct-entry midwife, Emma (TGH))

Emma's words indicate that by means of sufficient information support the identity as a professional midwife has been recognised by their service users and in return midwives' perceived competence in supporting normal childbirth has been strengthened. Thus, empowering women with the belief in normal birth has shown its effectiveness in increasing the credibility of the midwives and resisting the medical dominance.

Furthermore, via building alliances with women there was also the effect that the value of being a professional midwife can be recognised by the work organisation. As Linda commented, compared to the obstetric techniques, the value of the midwife was more intangible, whereas it can become visible through the women's feedback of their experiences:

At the beginning of the midwife-led unit, the hospital management didn't understand much of what we were doing. When they found the women in MLU are more understanding and more satisfied with the service compared to those in the traditional units, and the caesarean rate was dropping off, they began to appreciate the role of the midwife-led care. Now this midwife-led unit has attracted many labouring women to give birth in our hospital. They [the managers] started realising the significant changes we had made. See, women's satisfaction is the best advertisement for promoting us. (Direct-entry midwife, Linda (TGH))

As Linda said, 'women's satisfaction is the best advertisement for promoting us'. Therefore, the value of the midwife was represented in the women's recognition of the care provision which demonstrated midwives' expertise in childbirth, and the uniqueness of their professional identity to the maternity care institution and to the public.

7.3.3 Shaping the Organisational Context

More explicit strategies that midwives adopted to engage in the professional discourse are in shaping the organisational context. Midwife managers in TGH have introduced the midwifery model into their unit by establishing a midwife-led labour room, which has created opportunities for midwives to apply the professional discourse ('being with woman' and 'advocating normal birth') and internalise these ideological constructs into their own ideology of practice. Through exerting midwifery leadership and integrating the professional discourse into the work ethos, these midwives were shaping the organisational context where they worked.

Midwives have revealed that professional discourse is likely to be enacted if the midwife managers can exert their leadership to support it. The application and continuous use of the midwife-led labour room could partly be seen as the outcome of such leadership. As one of the initiators of the midwife-led labour room, Linda told me her managerial position has endowed her with more opportunities to negotiate with the organisation and enabled her to bring professional ideology into practice:

Since I was promoted to a head midwife, I am more able to apply midwifery values into care provision, which I couldn't do before. Although it is still difficult to gain the full support from the administration level, I am trying to create conditions to do what I possibly can. For example, the application of the midwife-led labour room [with the help of international midwifery scholars], to improve the antenatal care classes and create training opportunities for midwives. (Direct-entry midwife, Linda (TGH))

By the means of leadership, Linda has played a mediating role between the work organisation and the staff midwives, which created more opportunities for midwives to identify with the ideological constructs in practice.

For the staff midwives, the experiences and practices that they learned in the midwifery model have encouraged them to integrate 'with woman' value into their work ethos. These midwives showed their determination to live up to the ideology of being with woman, no matter where they worked. The following example explains how Daisy shaped the context for the women's needs during her shift in the traditional labour rooms:

Even in the traditional labour ward, we tried to do things according to the woman's needs. We tried our best to be there for her, listen to her, encourage her to articulate her needs and inform her about the progress. (Direct-entry midwife Daisy, (TGH))

Midwives in hospital TGH have also practised in and acquired the normal birth knowledge and skills from the midwife-led labour room, which helped to build up their competence in advocating normal birth. The competence that midwives acquired from these experiences and practices in turn strengthened their beliefs in normal birth. They therefore have consciously instilled the value of 'normal' into the traditional labour rooms under the medical model whenever they worked there:

I brought the knowledge I'd learned from the midwife-led unit to the traditional labour ward, such as how to breathe, keep relaxed and cope with the labour pain, change to a comfortable position during labour and birth. When I internalise this knowledge into my own ideology, even when still under the medical model, I feel more able to fulfil my role. (Nurse-midwife Fiona, (TGH))

Even though these midwives admitted that they were still hovering on the boundary of the medical system, with supportive knowledge they felt in a better position to take on the role of an advocate for normal birth. Midwives' on-going professional development in the midwifery model was deemed a vital means of helping to reinforce for midwives the distinctiveness of their professional identity in relation to their knowledge, skills and role.

The experience of working in the midwifery model has enabled the midwives in TGH to exert their agency in the face of the organisational structures. More importantly, by creating

a humanistic and 'normal' atmosphere in the workplace, these midwives' enactment of their professional ideology has exerted an impact back upon the organisational management, as Linda said:

In our unit, the whole working atmosphere is more humanistic now, because we are trying to apply caring values and advocate normal birth thoroughly in practice. The differences in midwifery care between the midwife-led and the traditional labour rooms seem to be gradually diminishing. (Direct-entry midwife Linda, (TGH))

With the implementation of the midwife-led labour room, TGH was the hospital where the midwives' negotiations with the organisational management appeared to be most evident. While midwives internalised professional discourse into their professional self, their practice has made a difference to the organisational structure. It implies that although work organisations seem to exercise power to control the resources and regulate the midwives involved, there is the possibility that midwives enact their agency to shape the organisational context.

7.4 Consequence: Hybrid Identity

The study has revealed that individual midwives have identified two types of strategies to construct their professional identity in hospital settings: compromise with organisational management and engagement in professional discourse. As a consequence, the different strategies within each type (compromising or engaging strategies) that midwives employed have driven them towards the external definition of 'obstetric nurse', or alternatively in a progression towards the internal definition of 'professional midwife' to varying degrees.

As indicated in previous analysis in this chapter, individual midwives often employed more than one strategy in dealing with the competing identities and sometimes the strategies seem to be contradictory. The most common but contradictory strategies that midwives used were 'settling the self on the work role' whilst 'enacting the midwife role whenever

possible' (see sections 7.2.1 and 7.3.1). Midwives usually chose to focus on the technical tasks or acquiesce in the medical protocols when their professional ideals were repressed by organisational management. However, when there is a possibility they endeavoured to engage in professional discourse. For example, when there were available midwife students or midwives who came to the unit for on-the-job training, these midwives would try to have them be there with women; or when the obstetricians were occupied, the experienced midwives or midwives who have practised in midwifery model would eschew the medical protocols to advocate normal birth. Moving between these two seemingly contradictory strategies reflects midwives' intentions of retaining both their internal ('professional midwife') and external ('obstetric nurse') definitions of the midwife while ignoring the identity dissonance. It also implies that individual midwives' construction of their professional identity is dynamic, depending on the definition of the situation and the experience of the midwives.

The adoption of the strategy 'detaching the self from professional ideology' was influenced by midwives' relationship with women (see Section 7.2.2). Under the work stress of 'women's dissatisfaction with care' and 'women's reliance on medicalised birth', at times some midwives chose to disengage themselves from the caring role or hand over their responsibility to the obstetricians (see Section 7.2.2). Such strategy reflects midwives' tendency to take on their external definition of the midwife ('obstetric nurse') by disengaging the central tenet of their professional identity.

Some of the midwives in this study seemed to 'immersing the self into work ideology' without noticing the identity dissonance (see Section 7.2.3); this appears to be influenced by their opportunities for professional development. Working purely in the medical-technical oriented environment without participating in professional development activities supported by midwifery discourse, these midwives were inclined to take on the role of 'doula midwife' and take in the medical view without consciously feeling the conflict. Such immersion implies that these midwives have potentially taken in the external definition of

the midwife ('obstetric nurse') unconsciously, which put the midwives at the risk of losing their own internal definition ('professional midwife') and being detached from professionalisation.

'Building alliances with women' in care provision was one strategy that midwives used in order to engage in their professional ideology (see Section 7.3.2), which has been influenced by midwives' relationship with women. These midwives made efforts to empower women by providing them with sufficient support, which has helped to establish women's confidence and beliefs in normal childbirth. By this means, these midwives have potentially made allies with women clients, who enabled the midwives to better negotiate with the organisational management. The adoption of this strategy reflects midwives' attempts to resist their external definition ('obstetric nurse') by seeking allies from the significant others.

The more explicit engaging strategy 'shaping the organisational context' was more likely to be employed by the midwives, who had experiences of practising in the midwife model (see Section 7.3.3). These experiences appeared to have enhanced midwives' perceived competence and commitment to the professional discourse and consequently enabled them to exert their agency to make a change of the organisational structures. Such strategy implies that midwives have internalised the internal definition of the midwife ('professional midwife') into their professional self through engaging in a substantial change to the organisational structure.

According to the consequences of the coping strategies analysed above, none of the midwives in this study seemed to fit purely in either the external definition of 'obstetric nurse' or the internal definition of 'professional midwife'. It suggested that individual midwives have constructed their professional identity in a dynamic process involving a constant structural and attitudinal interplay between the external and internal definitions of the midwife, being influenced by their experiences, relationships with women, opportunities for professional development and the definition of the situation. Therefore, for the

individual midwives in this study, the construction of their professional identity was navigated along an identity continuum with the external definition 'obstetric nurse' at one end and the internal definition 'professional midwife' at the other, thus giving rise to a 'hybrid identity' (See Figure 7).

7.5 Discussion: Identity Dissonance Reduction and Hybrid Identity

Findings in Chapter Six have revealed that the construction of the hospital-based midwives' professional identity was subject to two competing identities: the external definition ('obstetric nurse') that is linked to the current organisational management of focusing on the task and reducing the risk; and the internal definition ('professional midwife') that is bonded to their professional discourse of being with woman and advocating normal birth. The external definition and internal definition of the midwife gave rise to a sense of cognitive dissonance in the hospital-based midwives in their professional identity construction. The experience of cognitive dissonance resulted from holding two competing identities termed by several scholars as 'identity dissonance' (Costello, 2005: 28). When constructing their professional identity in the hospital settings, such 'identity dissonance' has stimulated midwives to engage in a process of dissonance reduction to lessen the unpleasant tension (Festinger, 1957). Two main dissonance reduction methods were employed by the midwives: compromise with organisational management and engagement in professional discourse. Within each method, there were three different forms of coping strategies identified, which either drive the midwives towards the external definition 'obstetric nurse', or alternatively facilitate them towards the internal definition 'professional midwife' to varying degrees. A hybrid identity was generated as a consequence.

In the literature review chapter, four types of identity work of managing identity dissonance identified in the studies that are underpinned by identity politics were reviewed (in Section 3.3.4): realigning these conflict identities; adopting the identity in the dominant social structure, while replacing the identity in conflict with the dominant one; creating a new professional role; consciously resisting the identity that dominant cultural values entail (Costello, 2005). In the following section, how these four forms of identity work are related to the action/interaction strategies that midwives adopted to work on their professional identity is discussed with reference to the relevant literature in midwifery.

7.5.1 Compromising Strategies

The study found that the strategies that midwives adopted to compromise with the organisational management have driven them towards the external definition of the midwife: the 'obstetric nurse'. Through 'settling the self on work role', 'detaching the self from professional ideology' and 'immersing the self into work role', individual midwives have constructed their professional identity towards the 'obstetric nurse' to a varying degree.

Compromise can be seen as a common strategy of avoidance from the cause of conflict (McElhinney, 2008), as it seems to be an easier way for midwives to 'conform than to work against this system' (O'Connell and Downe, 2009: 600). Encountering the conflicting requirements from the work organisation and the profession, the coping strategy of 'settling the self on the work role' is in accordance with the identity work of refusing to make choices by realigning the conflict identities (Costello, 2005); while the strategy of 'detaching the self from professional ideology' is akin to the identity work of adopting the identity in the dominant structure (Costello, 2005). In the context of this study, those midwives either pragmatically settling the self on the work role or detaching the self from professional ideology have taken on the role of the obstetric nurse to avoid perceived 'emotional distress' (see section 6.2.1.4) and 'risk concerns' (see section 6.2.2.4). These are the common compromise strategies used by the 'street-level bureaucrats' (Lipsky, 1980), who often exert their constrained discretion to pragmatically manage the competing role expectations at work. However, for the midwives in this study, such pragmatic needs to compatibly fit in the working context have the potential to undermine the ideological constructs that midwives claimed as the basis of retaining their desired professional self. These compromise strategies may allow midwives to keep both competing identities, but have in part altered the very essence of their professional identity. The findings are reminiscent of hospital based midwives in many other counties (Finlay and Sandall, 2009, O'Connell and Downe, 2009): for example, the 'with institution' midwives in Hunter's (2004: 261) study on

emotional labour; the cold professional categorised by McCrea and Crute (1991); the non-caring midwives described by Halldordottir and Karlsdottir (1996); and the prescriptive midwives found by Bluff (2003). The coping strategies as such, as Rosenfeld and Foley (2007: 4) argued, have forced 'midwives to attempt to incorporate competing identities, thus working against the self they make every effort to present'. Such compromise, or in Wenger's (1998: 178) term, submissive 'alignment' to the institutional values, is a common coping strategy used by the marginal professionals (Hendry, 1975). The identity work alike may to some extent limit the dissonance source, but has enhanced the power of the dominant social structure at the cost of keeping midwives in a marginal status and a state of prolonged experience of dissonance.

It is noteworthy that in this study some midwives seemed to be immersing the self into the work role without consciously feeling the conflict. The way these midwife participants' unconsciously take in the medical view has in fact confirmed the medical culturalism in the study context. As the values of the medical group have become the norm, the subordinate midwifery group is likely to be acculturated into the medical way of being and may fail to recognise its own value (MacIntosh, 2002), particularly when the medical norms are policy oriented in the context of this research. These midwives have some resonance with what Lane (2002: 28) summarised as 'obstetric-assistant' midwives. Such compromise strategies put midwives at the risk of losing their own professional identity and can detract from their professionalisation.

Likewise, the midwives, who readily took on the role of 'doula midwife', are also in danger of giving up their own professional identity. The popularity of the 'doula' programme with the midwives in this study can be seen as a product of the practical needs to fill the gap between the organisational management and the service users' requirements. Studies in other countries have showed that as a paraprofessional in maternity care teams, doulas' continuous support during labour and birth can increase women's satisfaction with their birth experiences and reduce the need for interventions (Lantz et al., 2005, Hodnett et al.,

2013). However, there are also studies that revealed midwives' resistance to the application of doula services, as handing over the caring role to doulas make midwives feel like they are losing part of their identity (Ballen and Fulcher, 2006, Stevens et al., 2011). The way that doulas were employed in China has its own characteristics in that the majority of doula services were provided by on-the-job midwives when they were off duty. By this means, the western meaning of 'doula' – the 'female servant' (Mander, 2001: 114), the 'woman caregiver of another woman' (Lantz et al., 2005: 110) or the modern 'paraprofessional' – has been converted into the 'privately hired doula midwife' in China (Cheung, 2009: 235). The current study found not only could such pragmatic use of a 'doula midwife' increase midwives' confusion in their professional role, it also has the potential to degrade midwives' professional status with regard to the original meaning of 'doula'. In this study, one third of the midwife participants graduated in nursing programmes. It has been argued that such a position may affect those nurse-midwives' ability to question the threat imposed by the emerging role of doula or the de-professionalised meaning of 'doula midwife' (Mander and Cheung, 2005). Nevertheless, it is noteworthy that in the current study midwife managers were the actual initiators of the doula programme while some staff midwives (including direct-entry midwives and nurse-midwives) seemed to take on the 'doula midwife' role without noticing its subversive influence on their professional identity and the professionalisation of midwifery itself.

7.5.2 Engaging Strategies

The study found that the strategies that midwives employed to engage in professional discourse have facilitated progression towards the internal definition of the midwife: the 'professional midwife'. Through 'enacting the midwife role whenever possible', 'building alliances with women' and 'shaping the organisational context', individual midwives have constructed their professional identity towards the 'professional midwife' to a varying degree. Being facilitated by professional and theoretical discourses, midwives were involved in a range of their own professional development activities to learn, strengthen and apply

professional ideology into practice. Such engagements have served as a powerful resource for professional identification (Wenger, 1998), enabling midwives to negotiate with the organisational management.

The strategies 'enacting the midwife role whenever possible' and 'building alliances with women' identified in this study are consistent with the identity work of consciously resisting the identity that dominant cultural values entail (Costello, 2005). Such engagement strategies echo what Lipsky (1980: 14) has suggested; in order to practise in more professionally acceptable ways, the 'street-level bureaucrats' attempt to resist the organisational structure by creating their own working 'rules'. It is reminiscent of some studies in midwifery literature, particularly Rosser's (1998) 'breaking the rules', Hunter's (2004) 'with women' ideology and what Kirkham (1999: 736) termed as 'doing good by stealth'. By employing such engagement strategies, some midwives in this study have attempted to enact their professional discourse in a more devious way rather than confronting the maternity care system directly. However, since 'both the aims, and the activity itself are concealed', midwives only felt able to achieve marginal professional success, as Kirkham (1999: 736) pointed out.

In the current study, the explicit engagement is the application of a midwifery model in the study site (TGH), which has created opportunities for some midwives to learn, reinforce and identify with the professional essences in a form of community of practice (Wenger, 1998). In so doing, the overt engaging strategy 'shaping the organisational context' was able to be carried out. Instead of creating a new professional role, the identity work that has been revealed by the studies based on identity politics (Costello, 2005) – the engagement strategy 'shaping the organisational context' in this study – indicates that these midwives have internalised the professional discourse into the self through engaging in a substantive change to the organisational structure.

Midwife participants in this study also suggested that other professional development activities, such as the recent international exchanges, have facilitated thinking and reflection. However, with regard to the meaning-making process of being a professional midwife, the midwives in the traditional (medical) model were not sure until they gained the opportunity to practise in midwifery model. This is evident in Catherine's words:

I have been in midwifery care my whole working life, since 1976. Even when I was promoted to nursing director, I was still concerned with midwifery care and midwives in obstetric departments. In fact, at that time I was dissatisfied with midwifery care. Since the initiation of the midwife-led labour room, I feel I've started understanding what is and how to be a midwife, from the definition, the role, scope of practices. By applying a midwifery model in our unit, our value of being a midwife can be recognised. Before I retire I will feel I have finally understood how to be a midwife. This question had confused me all those years. (Midwife, Catherine (TGH))

Catherine indicated that the absence of professional learning opportunities in the past inhibited midwives from identifying with professional and theoretical discourses. The experiences of practising and participating in midwifery model have enabled midwives to apply the professional ideals of being with woman and advocating normal birth in practice, which can in turn facilitate these midwives to internalise these ideological constructs and feel more assured of being a professional midwife. It is through on-going professional learning and practice in midwifery model these midwives have potentially developed the sense of who they are and what they are competent of doing. Therefore, these findings suggest the possibility that hospital midwives can enact their agency to achieve the ideal way of doing the job, and thus identify themselves with their ideological constructs. More importantly, via the engagement strategy 'shaping the organisational context', there were also indications that the organisational structure can, possibly, be reorganised.

7.5.3 Hybrid Identity

Data in analysis revealed that the midwives often employed more than one strategy in dealing with the competing identities, which have been influenced by their experiences, relationships with women, opportunities for professional development and the definition of the situation. The consequences of these coping strategies suggest that the construction of individual midwives' professional identity was navigated along an identity continuum with the external definition 'obstetric nurse' at one end and the internal definition 'professional midwife' at the other, thus giving rise to a 'hybrid identity'. The majority of the midwife participants adopted the strategy 'settling the self on the work role' and left the professional ideology aside temporarily, whilst they sought opportunities to 'enacting the midwife role whenever possible' (see sections 7.2.1 and 7.3.1). Such shifts between the two seemingly contradictory strategies reflect midwives' attempts to retain both the internal ('professional midwife') and external ('obstetric nurse') definitions of the midwife. The findings, though based in the context of China, could go some way to supporting Davis-Floyd's (2007: 705) interpretations of the 'postmodern' midwives or Lane's (2002: 26) descriptions of the 'hybrid' midwives in the broader settings. However, either Lane's (2002) 'hybrid' midwives or Davis-Floyd's (2007: 705) 'postmodern' midwives implies that midwives' blending practices are grounded in the individuals' own manner of understanding childbirth, which has become their own ideology that guides practice and formulates an individual's professional identity. Differently indicated in the current study, the construction of the 'hybrid identity' in individual midwives was a consequence of the constant structural and attitudinal interplay between the external ('obstetric nurse') and internal ('professional midwife') definitions of the midwife. Therefore, although midwives attempted to keep both of their internal and external definitions by constructing a 'hybrid identity', the identity dissonance would continue to exist.

It has been an almost universal issue that midwives worldwide are hovering between the medical-techno and the midwifery approaches to childbirth (O'Connell and Downe, 2009),

as their everyday practice requires them to merge constituents of both models. For this reason, there are concerns about if the ideologies of the midwifery model and the medical model are referenced in stark relief to each other, midwifery may fail to truly define itself (Annandale and Clark, 1996: 29), whilst midwives may be unable to seek the authentic self (O'Connell and Downe, 2009). As Page (2010) proposed, individuals' practice ideology would be based on their own values and beliefs of childbirth, which may not be necessarily connected with a professional loyalty. In this sense, we may accept that there are different types of midwife, whose work is underpinned by different ideals and values (Hunter, 2004). However, it is worth noting that although in this study midwives' pragmatic decisions were largely made on their own, these were in part the product of their institutional nursing position in the maternity care system. Other than framing their professional identity on the basis of individuals' own values, the strategies 'settling the self on the work role' and 'detaching the self from professional ideology' reflect the midwife participants' powerlessness in exerting their professional discretion in the current maternity care system.

In Chapter Five, in terms of the midwives' institutional nursing position, the marginalised status of Chinese midwifery in relation to medicine and nursing groups has been discussed. In practice, the term 'marginality' has been used to describe individuals' roles as being peripheral to the mainstream of the institution (Hendry, 1975, Wenger, 1998). The professional discourse, or the role of the professional midwife in this sense, is enacted at the margins of current organisational management. The identity of the midwife is thus comprised of multifaceted and often competing components, which are related to the situations in care provision in particular and the context of maternity care systems in general. The marginality of midwifery and midwives' endeavours to fit into the system may account for the formation of the hybrid identity.

7.6 Conclusion: Hybrid Identity in Midwifery

Analysis of the data in this chapter presented how individual midwives addressed the dissonance resulting from the interplay between external and internal definitions of the midwife. Two types of action/interaction strategies have been elucidated and discussed. Although it was analysed in Chapter Six that all midwives have discursively claimed their professional identity by drawing on relevant professional constructs, the different coping strategies in practice serve as a reminder that each individual has constructed their professional identity differently. They were found to be navigating on an identity continuum; with one end being an 'obstetric nurse' to the 'professional midwife' at the other end, resulting in a hybrid identity. In the next chapter, the categories discussed in the three findings chapters are integrated to present and discuss the theoretical model developed from this thesis.

CHAPTER EIGHT: THEORETICAL MODEL – NAVIGATING THE SELF IN MATERNITY CARE

8.1 Introduction

The study aimed to explore how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. According to the study aim, three research questions were specified. Along with drawing on relevant data to address the research questions, the analysis of the gathered data enabled the development of a theoretical model for this study. The six principle categories analysed in the preceding findings chapters (Chapters Five, Six and Seven) have presented the contextual nature of professional identity construction in midwives, the competing identities defined by their work organisations and the midwifery profession, the identity dissonance that the competing identities caused, the varying strategies that midwives adopted to reconcile the dissonance and the hybrid identity resulted from these coping strategies. Together, I've referred to relevant literature to discuss the categories in each chapter. In this chapter, I integrate the six principle categories analysed in the prior three findings chapters to present the theoretical model developed from the data and to indicate how the developed model can answer the research questions. The theoretical model is diagrammatically presented and illustrated in Section 8.2. Section 8.3 indicates how the research questions guiding the study are addressed by linking to the relevant elements of the theoretical model.

8.2 Theoretical Model: 'Navigating the Self in Maternity Care'

Although a substantial theory may be hard to construct, basic theoretical concepts and their inter-relationships can be developed (Charmaz, 2006). A theoretical model was developed through the integration of six principle categories and the constituent sub-categories discussed in the previous three findings chapters. A core category 'navigating the self in maternity care' was identified to explain how hospital-based Chinese midwives construct

their professional identity in an effort to fit into the contemporary maternity care system while not losing their professional sense of the self. The core category, six principle categories, and thirteen sub-categories were constructed and interrelated by using the 'paradigm' framework (Strauss and Corbin, 1998: 123) and presented in Figure 2 (Section 4.4.7.1). Through analysis a visual representation of the model (Figure 3 in Section 4.4.7.1) was developed and re-presented here for ease of reference.

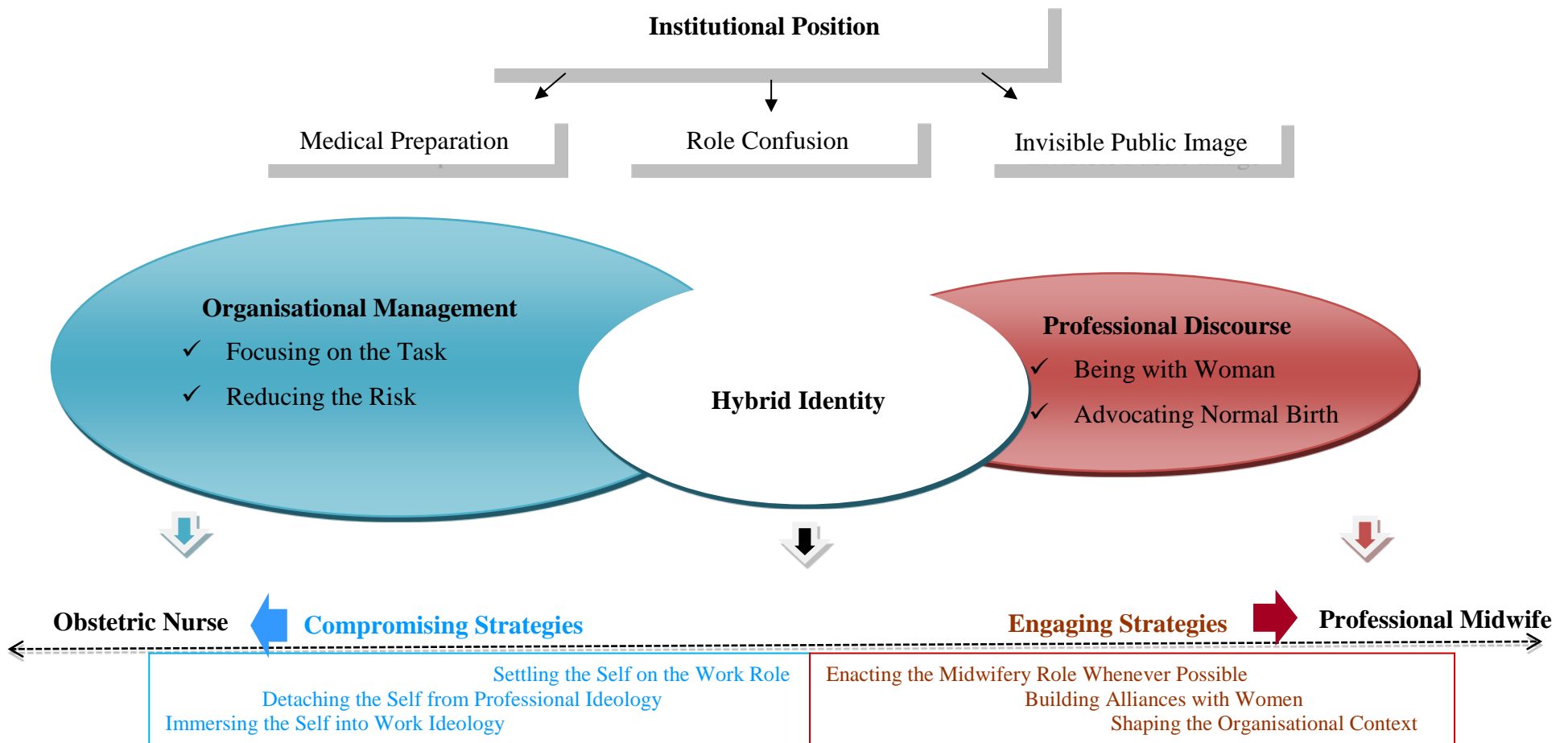
The model illustrates that the construction of hospital-based Chinese midwives' professional identity was contextualised in the 'institutional position' of the midwives in the contemporary maternity care system, through the 'medical preparation', 'role confusion' and 'invisible public image' of the midwives. The midwives' institutional nurse position has exerted broad impacts upon the 'organisational management' and 'professional discourse' underlying midwifery practice, which determines individual midwives' professional identity construction in hospital settings.

In hospital settings, individual midwives' professional identity was constructed at the intersection of two competing identity constructs defined by their work organisations and midwifery profession. 'Organisational management' demonstrates the identity constructs defined by the work organisation, which confined midwives to the role of an obstetric nurse to focus on the task and reduce the risk. 'Professional discourse', on the other hand, demonstrates the constructs that midwives used to define themselves as a professional midwife to be there with woman and advocate normal birth. The two categories 'organisational management' and 'professional discourse' build upon each other to demonstrate the interplay between the external definition ('obstetric nurse') and internal definition ('professional midwife') of the midwife in practice. The co-existence of these two competing identities resulted in identity dissonance for the individual midwives in their daily practice.

In response to the dissonance, midwives have adopted two types of coping strategies: 'compromising strategies' and 'engaging strategies'. Within each dissonance reduction method, the different strategies ('settling the self on the work role', 'detaching the self from professional ideology', 'immersing the self into work role' or 'enacting the midwife role whenever possible', 'building alliances with women', 'shaping the organisational context') that individuals employed have driven them either towards 'obstetric nurse' or, alternatively, progressing towards 'professional midwife' to varying degrees.

Revealed in the study, individual midwives often employed more than one strategy to reconcile the dissonance. The adoption of each strategy involves a constant structural and attitudinal interplay between the external definition ('obstetric nurse') and internal definition ('professional midwife') of the midwife, being influenced by midwives' experiences, relationships with women, opportunities for professional development and the definition of the situation. As a consequence, the individual professional identity was actually constructed in a dynamic process, navigating along an identity continuum between 'obstetric nurse' and 'professional midwife' at opposing ends, leading to a 'hybrid identity'.

Figure 3: Theoretical Model - 'Navigating the Self in Maternity Care'



8.3 Answering the Research Questions

Central to the model presented in Figure 3 is the dynamic interplay of the external and internal definitions of the midwife between their work organisation and the midwifery profession. The midwives' institutional position in contemporary maternity care system appeared to have exerted contextual influence upon the process of construction through the medical preparation, role confusion and invisible public image of the midwives. In the contemporary maternity care system, although midwives presented their ideological concepts (being with woman and advocating normal birth) as identifying constructs to define their professional identity, their institutional position and the management of the work organisations constrained them to the role of an obstetric nurse to focus on the task and reduce risk. Individual midwives' professional identity appeared to be dynamically constructed at the intersection of the two competing identity constructs (one is regulated by the 'organisational management' and the other is defined in the 'professional discourse'). Such a dynamic process is mediated by their experiences, the definition of the situation, their relationship with women, and opportunities for professional development. After illustrating how the basic theoretical categories interrelate to develop the model formed from this study, in this section I am going to discuss how the model developed as I addressed my original research questions:

- What constructs are drawn on by hospital-based midwives to define their professional identity?
- How do midwives construct their individual professional identity in hospital settings?
- What factors contribute to the construction of individual professional identity in hospital-based midwifery practice?

8.3.1 The Professional Identity Constructs – ‘Professional Discourse’

The category ‘professional discourse’ in the model (analysed and discussed in Chapter Six) presented the constructs that the hospital-based Chinese midwives identified to define their professional identity. These are the ideological concepts – ‘being with woman’ and ‘advocating normal birth’ – that were espoused academically in the professional and theoretical discourses of midwifery. Findings in this study revealed that midwives intended, and had a desire, to identify themselves with these ideological constructs, as they considered these as central to defining their professional identity with midwifery. Their identification with these ideological concepts was strengthened through a variety of informal professional development activities initiated on their own (e.g. initiating and participating in midwifery models of care, accessing international journals, attending midwifery conferences, exchanging knowledge with visiting midwives from other countries, clinical training in other units, and learning activities within their own units).

One of the constructs that midwives in this study used to define their professional identity is ‘being with woman’. This ideological construct was employed by the midwives to lay emphasis on the central role of the women in the survival of the midwifery profession as well as the quality of midwifery practice. All midwives in this study agreed that being with woman is an integral part of their professional identity, which reflects their professional need to establish good relationships with women as well as their personal value of caring for women. In midwifery literature, ‘being with woman’ is deemed as a central philosophy associated with midwifery care (Kennedy, 2000, Hunter, 2002, ICM, 2011a). This concept highlights the midwifery focus as being on ‘women-centred’ care and the view of birth as a normal life event, which has been used to differentiate the midwifery-led approach from the obstetrician-led approach in maternity care (Kennedy, 2000, Hunter, 2002, Carolan and Hodnett, 2007). As reviewed in Chapter Three (Section 3.4.2), the use of the ‘with woman’ concept in midwifery literature has covered the whole range of midwifery practice (including pregnancy, labour and birth, and postpartum) and has often been interpreted

together with other important midwifery concepts 'woman-centeredness', 'holism', 'in partnership' and 'continuous care/carer' (Carolan and Hodnett, 2007, Walsh and Steen, 2007, Fleming, 1998). In the current study, the concept of 'being with woman' was emphasised by midwife participants with regard to its clinical aspects of caring for labouring women, as these hospital-based midwives' works were primarily laid in labour wards. These midwives considered 'being with woman' as one of the constructs to define their professional identity and interpreted this identity construct as the caring role of being present and providing the physiological, emotional and informational care and support that is needed by the labouring woman.

'Advocating normal birth' is another construct that midwives in this study used to describe their professional identity. Midwives employed this ideological concept to articulate their stance in opposition to the current medical protocols, and to distance themselves from the expertise area of the obstetricians in order to gain a better position to resist their institutional position as an obstetric nurse. As a controversial term discussed in Chapter Three (section 3.4.2.3), there is no consensus of what exactly 'normal birth' means amongst the midwife participants in this study. All midwives espoused the role of normal birth advocates, but their attitudes towards the medical protocols altered in different aspects. For example, some midwives stated that the current 'normal' time limits of childbirth were 'strict' and 'outdated', while others seemed to have accepted such medical standards without question. All midwives commented that the medical interventions (such as induction, labour augmentation and caesarean section) were overused, but only the midwives in TGH mentioned that their own midwifery technique (e.g. episiotomy) should not be conducted routinely.

Additionally, when presenting themselves as normal birth advocates, midwives also emphasised their expertise in the normal birth domain in comparison to the obstetricians' expertise in complications. Midwives highlighted that their experiences in assisting normal birth have played a crucial part in the development of their expertise in normal birth that is

considered as key to their identification with midwifery profession. The expertise developed through experience was synthesised by Downe et al., (2007:134) as 'wisdom', which refers to a high-level of capacity with 'profound understanding and deep insight' when taking care of labouring women. Apart from the clinical knowledge, skills and experiences in assisting normal childbirth, non-medical interventionist care centred on the philosophy of 'being with woman' was also highlighted by some midwives in this study as a way to distance themselves from the obstetricians' interventionist orientation. Such emphasis on midwifery expertise reflects these midwives' 'confidence to not act' (Downe et al., 2007:134), which, to some extent, echoes what Kennedy (2002:1759) termed 'the art of doing "nothing" well'.

This study found that although all midwife participants presented themselves as normal birth advocates, only some of them articulated the counterviews to the current medical standards of normal birth (the time limits of labour and birth) (e.g. Juliet and Catherine), were aware of overuse of episiotomy in their practice (e.g. Fiona and Yvonne) and applied the non-medical interventionist approach to childbirth (e.g. Jenny and Emma). Considering all midwives were prepared and located within a medical-technocratic approach to childbirth (linked to category 'medical preparation' in Figure 3; for detailed discussion see section 5.3.1), some midwife participants' acceptance of the medical 'normal' standards and routinised technological interventions (e.g. episiotomy) was not surprising. For others with clear understanding of how to be a normal birth advocate, they attributed such understanding to the opportunities of some informal professional development activities, particularly the self-study of the evidence-based midwifery knowledge, increasing international exchanges and participating in the midwifery model of care. The findings support that professional identity begins to be constructed in the educational and preparation stages, but it is an ongoing process of interpretation and re-interpretation of experiences throughout the life of the professional (Gregg and Magilvy, 2001, Johnson et al., 2012). Findings in this study indicate that continuing professional development with the support of midwifery discourse has the potential to facilitate such self-reflection and subsequently enable the midwives to construct their professional identity with midwifery.

In this study, the selection of 'being with woman' and 'advocating normal birth' as the constructs to define their professional identity with midwifery in practice, reflects midwives' discursive practices to legitimate their identity as a professional midwife by emphasising women as being at the centre of their practice rhetoric and establishing a boundary with the medical professionals. This can be interpreted as a form of discursive identity work (Oliver, 2007: 38, Watson, 2008), which midwives conducted to negotiate with their obstetric nurse identity assigned by the maternity care institution.

8.3.2 Contextual Constraints – 'Institutional Position' and 'Organisational Management'

The categories 'institutional position' and 'organisational management' in the model (analysed and discussed in Chapters Five and Six) represented contextual constraints which prevented midwives from identifying with the constructs they claimed to form their professional identity.

The category 'institutional position' suggests a marginal position for midwifery in the contemporary Chinese maternity care system, as midwives indicated that their formal jurisdiction has been blurred and marginalised by both of their interrelated groups; the medical profession and the nursing profession (detailed discussion see Section 5.3). Such a marginal position resulted in the 'medical preparation', 'role confusion' and 'invisible public image' of the midwives, which have paved the way to confining midwives in the task-oriented and risk-focused role of an obstetric nurse at organisational level (reflected in the category 'organisational management').

Firstly, midwives in this study commented that their daily practices were regulated by the organisational mandates of 'focusing on the task', which were viewed as one of the organisational obstacles that prevented midwives from identifying with their identity construct of 'being with woman'. Midwives expressed a variety of 'emotional distress'

arising out of the current organisational management, which pertains to the midwife shortage at work, their heavy workload and women's dissatisfaction with their care (detailed discussion see section 6.5.1.3).

Hunter (2002) has systematically analysed the concept of 'being with woman' from its theoretical, philosophical, physiological, and empirical perspectives, and recommended that there is a clear need to retain being with woman at the centre of midwifery routine practice. However, the current study revealed that the midwives and women did not consider that administrative health policies and managers valued the benefits that being with woman can produce, though it has been supported in evidence-based knowledge (Hodnett, 2002, Hodnett et al., 2013). As they were operated at a policymaking level, midwives felt not being able to contemplate influencing this ideological concept in their daily practice as 'street-level bureaucrats' face (Lipsky, 1980). Taking the midwife staffing allocation for example, midwives commented that it is far from adequate for them to fully be there for women and to enact their professional role. They implied that the underlying reason for the absence of understanding and support from the administrative policies and managers is their institutional nursing position. Being assigned a 'nurse' identity, the positions and resources relevant to the obstetric nurses were conferred on the midwives, and thus prevented the role of the midwife from being fully recognised and acknowledged at organisational level (linked to the category 'role confusion' in Figure 3).

Being unable to provide sufficient care and support to women has also evoked women's dissatisfaction with the care that midwives provided. Through the disempowerment from fulfilling their professional ideology of being with woman, coupled with the high workload and the subsequent tension with women clients, midwives expressed a clear sense of emotional distress particularly the feeling of burnout. As Purkis (2006: 254) quoted in Anderson (2005:474):

If a midwife works in a midwifery service which embodies technocratic values, she will not be enabled to provide humanistic care to clients in that service. She may try, but surrounded as she is by technocratic values that predominate, the internal dissonance she will experience will be great, and the personal cost will be high. (Anderson, 2005:474)

Previous studies on midwives' feeling of burnout have also found the workload and relationships with service users to be the major causes, but these studies mainly focused on the experiences of community midwives (Bakker et al., 1996, Sandall, 1997, Yoshida and Sandall, 2013). Of burnout studies that directly relate to midwives' professional identity, there is the work of Rosenfeld and Foley (2007), which examines the work strains that the Florida midwives experienced. The study identified the incompatibility between midwives' self-ideals and their political and legal positions at the margin of the medical system, and concluded that working constantly against the self is the source of burnout (Rosenfeld and Foley, 2007), which is supported by the current study.

Secondly, midwives in this study have also indicated that overall the workplaces were structured by medical models of care. They commented that their professional ideal of 'advocating normal birth' was often repressed by the organisational focus on 'reducing the risk'. Midwives expressed a range of 'risk concerns' underlying the midwife role of a normal birth advocate, which is related to the existing medical protocols, obstetricians' authority and women's reliance on medicalised birth (detailed discussion in Section 6.5.1.3).

The 'risk concerns' arose from the potentially adverse consequences of not following the medical protocols and obstetricians' authority, are consistent with the findings in O'Connell and Downe's (2009:599) meta-synthesis study, in which the hospital-based midwives in four countries (the UK, New Zealand, Norway and Ireland) were suffering from disempowerment under the 'power and control' of the medical model. However, compared to the midwives who have been experiencing powerlessness in promoting normal birth in many other countries e.g. (O'Connell and Downe, 2009, Donna, 2011), the institutional 'nurse' position of the midwives in this study seemed to aggravate their 'risk concerns'. As reflected in the

category 'role confusion' and 'invisible public image' (linked to the model in Figure 3), midwives' institutional 'nurse' position appeared to legitimate the obstetrician's authority to supervise midwives' practice and increase service users' reliance on the medical professionals. Such institutional influences further entailed obstetricians' leading position in the management of childbirth in hospital settings, while midwives felt being deprived of practising autonomously as a normal birth advocate.

Furthermore, 'risk concerns' resulted from women's attitudes towards medicalised births were shared in Green's (2006) study. Nevertheless, the perceptions from midwife and women participants in this study also suggested that the midwife staffing level and restricted support during childbirth for women have partly increased women's insecurity in childbirth, and provoked the subsequent request for medical intervention or even confrontation to midwives. Such consumerist pressure, partly derived from the current deficient organisational management, seemed to further affect midwives' confidence and belief in holding onto their professional identity construct to advocate normal birth.

Overall, the model suggests that although midwives endeavoured to identify themselves with their professional and theoretical discourses of 'being with woman' and 'advocating normal birth', the institutional and organisational context matters. These contextual constraints make many things an aspiration and an ideal rather than a reality to most hospital Chinese midwives. In order to fit in with the current maternity care system whilst not losing their professional sense of self, individual midwives have to adopt varying strategies to work on their professional identity, as discussed in the following section.

8.3.3 Individual Professional Identity Construction – a 'Hybrid Identity'

The model indicates that in hospital settings, individual midwives' professional identity was constructed at the interface of two competing identity constructs defined by their work organisations and midwifery profession. 'Organisational management' demonstrates the

identity constructs defined by the work organisations, which confined midwives to the role of an obstetric nurse to focus on the task and reduce the risk. 'Professional discourse', on the other hand, demonstrates the constructs that midwives used to define themselves as a professional midwife to be there with woman and advocate normal birth. The two categories 'organisational management' and 'professional discourse' build upon each other to demonstrate the interplay between the external definition ('obstetric nurse') and internal definition ('professional midwife') of the midwife in practice. The co-existence of these two competing identities in midwives' daily practice resulted in identity dissonance for the individual midwives, which triggered reconciling the dissonance and consequently working on their professional identity.

As illustrated in the model, midwives adopted two types of strategies to reduce the identity dissonance and work on their professional identity: 'compromising strategies' (concessions to organisational management) or 'engaging strategies' (engagement in professional discourse), which were discussed in detail in Section (6.5). The study revealed that midwives often employed more than one strategy to reconcile the dissonance. The adoption of each strategy involves a constant structural and attitudinal interplay between the external definition ('obstetric nurse') and internal definition ('professional midwife') of the midwife, being influenced by their experiences, relationships with women, opportunities for professional development and the definition of the situation.

The most commonly used coping strategies were 'settling the self on the work role' and 'enacting the midwife role whenever possible'. The majority of the midwives appeared to move between the two strategies at times, being influenced by the situation and the experiences of the midwives. The use of these two seemingly contradictory strategies reflects midwives' attempts to retain both of the internal ('professional midwife') and external ('obstetric nurse') definitions of the midwife while disregarding the identity dissonance.

In addition, some midwives attempted to protect themselves from potential emotional drain and legal disputes by 'detaching the self from professional ideology'. Such coping strategies indicate midwives' intentions to take on their external definition ('obstetric nurse') by disengaging the central tenet of their professional identity. Other midwives consciously negotiated with organisational control by 'building alliances with women'. Such engaging strategies manifest midwives' agency in resisting their external definition ('obstetric nurse') by aligning with significant others. The adoption of the strategies 'detaching the self from professional ideology' or 'building alliances with women' were related to midwives' relationships with women.

Furthermore, the midwives, who practised purely in medical-technical contexts without participating in professional development activities supported by midwifery discourse, were likely to 'immerse the self into work ideology'. These midwives seemed to be at risk of losing their professional sense of the self (the internal definition of the 'professional midwife') by taking in the external definition of the midwife without consciously feeling identity dissonance. For others, the experiences of practising and engaging in the midwifery model offered opportunity for them to 'shape the organisational context'. These midwives appeared to internalise the professional discourse into the self through engaging in a substantive change to the organisation structure. Whether midwives were 'immersing the self into work role' or 'shaping the organisational context' appears to be influenced by their opportunities for professional development, being supported by 'midwifery discourse'.

On the whole, these varying coping strategies in the model suggest that individual midwives have been constructing their professional identity in a dynamic process that involved a constant structural and attitudinal interplay between the external and internal definitions of the midwife. The compromising strategies ('settling the self on the work role', 'detaching the self from professional ideology' and 'immersing the self into work ideology') that midwives adopted to compromise with the organisational management appeared to drive them towards the external definition of the midwife – the 'obstetric nurse' – to varying

degrees; while the engagement strategies ('enacting the midwife role whenever possible', 'building alliances with women' and 'shaping the organisational context') that midwives employed to engage in the professional discourse seemed to facilitate a progression towards the internal definition of the midwife – the 'professional midwife' – to varying degrees. With the influence of their experiences, relationships with women, opportunities for professional development and the definition of the situation, in daily practice individual midwives seemed to keep adjusting the identity constructs (being with woman and advocating normal birth) that they used to define their professional identity. As a consequence, the construction of their professional identity was navigating along an identity continuum with 'obstetric nurse' at one end and the 'professional midwife' at the other, resulting in a 'hybrid identity'.

In terms of hospital-based midwives' experiences in dealing with the conflicts between their professional ideals and the reality of work settings and institutional imperatives, O'Connell and Downe (2009: 605) have synthesised 14 studies undertaken in the UK, New Zealand, Ireland and Norway, and theorised the experiences with reference to the notions of 'authenticity' and 'bad faith' analysed by Ashman (2008):

Seeking to perform 'real midwifery' is perceived by most midwives to be the authentic position of the midwifery profession. Cultural and environmental constraints can restrict the practice of real midwifery in hospital-based labour wards. In this circumstance, the authentic position is to recognize that there is a range of responses possible, including compliance, and discursive, subversive or overt resistance, and that each of these choices engenders personal responsibility. Bad faith is only evident when midwives assert that only one course of action is possible, and that this is dictated by powerful others and specific cultural and environmental conditions. (O'Connell and Downe, 2009: 605)

'Authenticity' in O'Connell and Downe's (2009: 605) analysis refers to midwives' consciousness of their authentic position and external constraints that restrict the pursuit of their authentic position. Having authenticity means individuals are able to employ agency to cope with the constraints through a range of responses. Having 'bad faith', on the other

hand, means midwives play the role determined by the external forces automatically without taking personal responsibility for negotiation. From the perspective of identity, the coping strategies that midwives adopted in the current study support the theoretical statement synthesised in O'Connell and Downe's (2009: 605) study. The shared ideological constructs that midwife participants in this study used to construct the 'authentic' sense of the professional self is akin to the 'real midwifery' that many midwives have termed for their professional ideals in O'Connell and Downe's (2009: 605) study. Consistent with O'Connell and Downe's (2009: 605) meta-synthesis, the way that midwives in this study used the ideological statements to define their professional identity in contrast to the organisational management could be regarded as a form of 'discursive resistance'; the coping strategies of 'settling the self on the work role' and 'detaching the self from professional ideology' can be seen as forms of 'compliance'; 'enacting the midwife role whenever possible' and 'building alliances with women' are means of 'subversive resistance'; 'shaping the organisational context' may be interpreted as 'over resistance'; and 'immersing the self into work role' is the one response akin to 'bad faith'.

With regard to the individual negotiation (identity work) between the two competing identities, it would be incomplete without discussing the impact of the midwives' agency in their professional identity construction. The interrelation between social structure and agency has been examined in relation to different theoretical focuses, from the humanist, structuralist, late modernity to post-structural approaches (Billett, 2006). In this study, individual midwives seemed to employ their agency to achieve mediation between the 'organisational management' and their 'professional discourse', which is evident in the resultant 'hybrid identity'. Considering the extent to which midwives in this study enacted their agency in maintaining their orientation towards the profession, the late modernity perspective of emphasising both subjects' self-regulation and self-subjugation in the process of identity negotiation is applicable to this study (Billett, 2006).

In terms of the interplay between the internal and external definitions of the midwife, having agency is regarded as being able to enact one's professional role in correspondence with one's core values and professional orientation (Vahasantanen et al., 2008). In the hospital settings where the midwives' identity constructs of 'being with woman' and 'advocating normal birth' are not given priority, there is a need for midwives to be clear about their professional orientation or what is important to them and have the ability to employ agency in care provision. The study revealed that the working context where midwives continuously constructed their professional identity has exerted significant impact upon midwives' understandings of their professional orientation and their subsequent practice of agency. In the meantime, professional development opportunities (such as experiences of practising outside of hospital, participating in the midwifery model of care, self-study of evidence-based midwifery knowledge, international exchange of conferences and visits) have strengthened their orientation towards the ideological constructs that they used to define their professional identity and enhanced their capacity for agency.

This study has demonstrated that the overall structure of the workplace emphasises a task-oriented and risk-focused approach (see 'organisational management'). Midwives' everyday practices were circumscribed by such structures which have the potential to direct midwives to this way of being, as evidenced in the compromise strategy 'immersing the self into work role'. In contrast to the other midwives, participants in TGH were working in a unit where a midwife-led labour room was operated within an overall medical-technocratic context. Participating in such a midwifery model, these midwives have learnt through practices in an environment which promoted midwifery. Accordingly, the 'meaningfulness' and the knowledge and experiences these midwives have learned from practices in the midwifery model were different to the others. These midwives spoke of the development of their professional identity as related to the midwifery model that they participated in. With these experiences, midwives reported that they were able to negotiate their practice with obstetricians and bring their professional ideals into the medical context, as revealed in the engaging strategy 'shaping the organisational context'. Learning through participation in the

practice of a community has been systematically analysed in the work of Wenger (1998), though in this study midwives' engagement in the form of community of practices was largely implicit. However, consistent with the study of Purkis (2006:12), this study shows that such practice-associated learning (in medical model or midwifery model) has the potential to either 'liberate or circumscribe' professional identity development in midwives.

In addition, midwives in this study also mentioned that professional development activities outside of their own community, such as the experiences of practising outside of hospital, self-studying of evidence-based midwifery knowledge and the international exchanges, have also encouraged them to reflect on their own practice and promote professional identity construction, as indicated in the engagement strategy 'enacting the midwife role whenever possible' and 'building alliances with women'. It demonstrates that professional identity construction is a process that continues throughout the lifetime of the professional, and ongoing changes in professional identity can be expected (MacIntosh, 2003, Johnson et al., 2012). In this study, only Jenny had experiences of working outside of hospital settings. Such practising experiences enabled her to enact the professional ideal of advocating normal birth by eschewing the medical protocols. The professional identity construction facilitated by the practices outside of the hospital setting is reminiscent of the community-based midwives' occupational identity in Hunter's (2004) study, which was found to be attached to the 'with woman' ideology. It also shares similarities with the experiences of the newly qualified midwife participant in Purkis's (2006:254) work, whose learning experiences in birth centres empowered her resistance to being identified with 'midwifery'. Nonetheless, concerning other forms of professional development activities (such as self-studying of evidence-based midwifery knowledge and the international exchanges), there were no studies specific to how this could be beneficial to midwives' professional identity construction. Only the study by Larsson et al. (2009) on Swedish midwives' professional role and identity changes has indicated that the research related to midwifery care has increased midwives' professional pride and enabled them to maintain their professional identity in the

organisation where there are increasing use of medical technology and more prescriptive guidelines.

8.3.4 Collective and Individual Identity

On discussing how the hospital-based midwives constructed their professional identity at the interface of two competing identities (professional midwife and obstetric nurse), Jenkins's (2008) distinction between 'groups' and 'categories' offers a theoretical explanation. According to Jenkins (2008), the professional midwife identity tied to professional discourse can be seen as the 'group' identity defined by the profession for itself, while the obstetric-nurse identity bound to the organisational management can be interpreted as the 'category' given by others. Jenkins (2008:157) explained that during social adaptation two identifying processes of the group (internal identification) and the category (external categorisation) can co-exist and interact at the 'boundary of identity'. For this study, the two identifying processes can be interpreted as 'professional discourse' and 'organisational management' that create competing identity constructs for the individual midwives and form the boundary for the construction of individual professional identities, wherein a range of political processes of 'negotiation, transaction, mobilisation, imposition and resistance' can be involved (2008c:157). At the intersection of the two identifying processes ('organisational management' and 'professional discourse'), although the definition of the midwife within the profession was highly espoused by the midwife participants, the various strategies that individuals adopted to reconcile identity dissonance have conveyed a message that the construction of individuals' professional identity differs. The conformity but not uniformity of the midwifery profession, or in other words, the collective and individual professional identities of the midwives can be understood by conceptualising the midwifery group on a different basis.

Based on social identity theory, the group can be regarded as 'a collective of similar persons' all of whom hold similar views in contrast with the out-group members (Stets and Burke,

2000:227). As Jenkins (2008) explicated, collective identity means that a group of people have something in common, whilst there are boundaries to the shared similarity, however ambiguous it might be. It is through these practices of similarity that we define what constitutes the boundary of difference. In this study, the collective identity of the midwife is manifest in the form of the discursive practices (or discursive identity work) that midwives employed through shared ideological constructs which underlie midwifery practice (professional discourse) and differentiate them from the obstetric-nurse identity assigned by the maternity care system.

Though collective identity emphasises the similarity that constitutes group membership, it is not at the expense of diversity within the group (Abrams and Hogg, 2004). However, the focus on individual identity is more salient in identity/role identity theory (Stryker, 1968, McCall and Simmons, 1978, Burke and Stets, 2009). For individual professional identity, the midwifery group can be viewed from the role identity perspective as 'a set of interrelated individuals', each of whom can hold their own perspectives (Stets and Burke, 2000:227):

Different perspectives are involved among the persons in the group as they negotiate and perform their respective roles, creating micro social structures within the group.

In this study, in responding to the identity dissonance the different roles that individual midwives enacted in everyday practice shows the 'micro-social structures' within the profession. For the individual, the role identity has been displayed through their role performance in a dynamic process of the enactment of respective constructs between the organisational management (focusing on the task and reducing the risk) and professional discourse (being with woman and advocating normal birth). Such dynamic interplay between the internal and external definitions of the midwife brought out a hybrid identity for the individual midwife as well as the professional group.

8.4 Conclusion

Working at the margins of the contemporary maternity care system, midwives have to cope with the competing identities in their daily practice. The theoretical model 'navigating the self in maternity care' developed through addressing the research questions for this study provides an understanding of how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. The general problem is that as a consequence of the navigation, the 'hybrid identity' may offer temporary alleviation to the identity dissonance. However, if midwives find most affinity with the obstetric-nurse identity, exerting no substantial influence, the profession will be continually placed in a marginal position. The danger would be seen as the consequence of the 'bad faith' (O'Connell and Downe, 2009: 605) of midwives immersing themselves in the institutional position, values and ideology and trying to identify with their work role, and thus ultimately neglecting their very commitment to and essence of being a woman-centred and normal birth oriented professional midwife. One resolution that demonstrated its significance in this study would be to enhance the role of professional development. This study offers evidence of how midwives' professional identity was embodied through engaging in professional learning and practices supported by midwifery discourses. For the midwives, the process of engaging in the professional ideology of being with woman and advocating normal birth, whilst laborious, led to midwives (and women) feeling empowered. Such midwives were moving towards the 'professional midwife' end of the identity continuum which is in accordance with their professional values and commitments, and enables the professionalisation of midwifery.

CHAPTER NINE: CONCLUSION

9.1 Introduction

This chapter is going to conclude the thesis. It begins with a summary of the study conducted along with my personal reflections of the research process. The implications of the research findings for midwifery practice, education and wider policy are considered. Recommendations for future research are offered at the end.

9.2 Summary and Reflections on the Research

The idea of conducting this research was raised by my discussions with several senior midwives and my personal experiences of doing master research in a maternity unit. When I prepared my doctoral study at the University of Edinburgh, these rudimentary thoughts became the topic of my proposal and further directed this study. During the time of preparing my first year review, I started to review the literature in terms of professional identity and midwifery. A literature review on professional identity identified a number of studies on identities in a variety of professional disciplines underpinned by different theoretical perspectives. The theoretical underpinnings for professional identity studies range from structural functionalism, symbolic interactionism, and identity politics to the recent trend of narrative/discursive identity. Based on these theoretical perspectives, a number of identity theories are employed to guide professional identity studies, such as social identity theory (Tajfel and Turner, 1979), role identity theory (Stryker, 1968, McCall and Simmons, 1978, Burke and Stets, 2009) and the internal-external dialectic identification (Jenkins, 2008). The focus of professional identity studies also varies from the characteristics of the professional identity, professional socialisation/professional identity formation to identity work (identity negotiation) that professionals enact when encountering identity crises or role transitions. The overloaded information of studies on professional identity at first did not help clarify my research focus, but brought me to a labyrinth wherein I got lost.

Assuming that despite the diverse directions of professional identity studies my research focus would rely on the way I looked at the study subject, so I decided to revisit the historical and political development of Chinese midwifery and review the existing literature of midwives' professional identity in the international context, rather than keeping myself in the labyrinth of the identity studies in other disciplines. In midwifery literature, only a small number of studies have elaborated on this topic. Several contextual factors influential in professional identity construction in midwives have been discussed in the previous studies, including the marginalised professional status in comparison to medicine, the intrinsic connection with the nursing profession, woman-midwife relationships, medicalisation in midwifery practice, and constraints of workplace structures. A few studies have engaged in midwives' identity negotiations in response to the contextual influences in relation to emotional work (Hunter, 2005), boundary negotiation and impression management (Foley, 2005), discursive use of medical discourse in practice (Foley and Faircloth, 2003) and legitimate peripheral participation (Purkis, 2006). Further review of the context of contemporary Chinese midwifery has found that the marginalised professional status (particularly its current subsumed position in the nursing profession) and medical dominance of midwifery practice have characterised the background for hospital-based Chinese midwives constructing their professional identity, but this has remained under-explored. Aiming at exploring how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system, the research questions were then developed:

- What constructs are drawn on by hospital-based midwives to define their professional identity?
- How do midwives construct their individual professional identity in hospital settings?
- What factors contribute to the construction of individual professional identity in hospital-based midwifery practice?

Since the research focus was identified as an under-explored area, particularly in the context of contemporary China, and my purpose of having an in-depth understanding of the construction of individual professional identities and the contextual factors that influenced the construction, Grounded Theory (GT) was chosen to guide this study. However, due to the development of GT methodology in the past four decades, a variety of approaches underpinned by different philosophical standings have derived from the GT family. I then faced another choice to be made. During my research there were several other PhD fellows doing their research guided by grounded theory. Therefore, apart from reviewing the studies of using GT, the discussions with colleagues were quite helpful for me to sort out the different versions of the GT family and clarify my position. Considering my previous understanding of the research area and my relationship with the prospective participants, Charmaz's (2006) Constructivist Grounded Theory (CGT) was taken for this study.

My fieldwork was conducted in a capital city (Eastern City) of a province in China from October 2010 to May 2011. The recruitment procedure was guided by a combination of purposive sampling and theoretical sampling. Data was collected through interviews with 15 midwives and 5 women clients. Three work journals were also offered by midwife participants. The process of gaining access to the participants and finally setting up the schedule for interviews was one of the most challenging elements of the study, due to my previous purpose of avoiding a potential sampling bias of gatekeepers' nominations and the tight work or life schedule of the participants (see Section 4.4.2). The interview process was both enjoyable and challenging. My background as a midwifery researcher and previous experiences in obstetric nursing helped me to establish rapport and encourage participants to share their views, perceptions and experiences. However, through reflection after each interview, I also realised I presented multiple identities when interacting with my participants during interview. Such reflexivity was beneficial for me in being constantly aware of my position during the interview and to develop my theoretical sensitivity to the research topic (see Section 4.3.3). Before the interviews, I personally assumed that Chinese midwives may have conceded to the institutional position and become immersed in the

corresponding role expectations in the maternity care system, as Chinese workers are usually not active in politics. Surprisingly, midwives have expressed a clear sense of resistance to the 'nurse' identity given by the maternity care institution and claimed the ideological constructs (being with woman and advocating normal birth) as the central tenets of their professional identity. Many of them were dedicated to enacting these ideological constructs to provide quality care for their clients despite the obstacles of the working context. I gained fresh insights into the complexities of midwives' identity construction in hospital settings and learned the variety of strategies they used to negotiate with the practical demands in work organisations.

The data analysis of GT always seemed to be more straightforward than it actually is. The coding procedures suggested by Strauss and Corbin (1998) and Charmaz (2006) were integrated and applied to this study. As a novice GT researcher, the open coding ends up with almost one thousand codes because I was afraid of missing out any important information. The sheer volume of the data and open codes made the constant comparison and identification of the categories difficult. The choice of doing the transcription and translation by myself actually helped in becoming familiar with each interview transcript and thus assisted with the constant comparison between each interview and the identified codes. The process of data analysis required great patience and sensitivity to the data and readiness to constantly go backwards for clarification and adjustment. Even during the time for writing up the findings, the developed categories and its constituent sub-categories were continuously modified and refined. Nevertheless, it is just the basic principle of GT – constant comparison – that helped me to wholly engage in the analysis and enabled the development of the theoretical model.

Finally, six principle categories were identified from the study: 'institutional position'; 'organisational management'; 'professional discourse'; 'compromising strategies'; 'engaging strategies'; and 'hybrid identity'. The integration of the principle categories has developed the theoretical model 'navigating the self in maternity care', which suggests that

professional identity construction in midwives is a dynamic process, involving a constant structural and attitudinal interplay between the external ('obstetric nurse') and internal ('professional midwife') definitions of the midwife. The model indicates that the midwives' professional identity construction was contextualised in their 'institutional position' in the contemporary maternity care system. In everyday practice, midwives experienced identity dissonance in relation to two competing identities: the 'obstetric nurse', bound to the 'organisational management' in hospital settings; and the 'professional midwife', associated with 'professional discourse' in the midwifery profession. Two types of strategies were identified to reduce the identity dissonance – 'compromising strategies' and 'engaging strategies' – which resulted in a 'hybrid identity', as the construction of professional identity in individual midwives is navigated along an identity continuum with 'obstetric nurse' and 'professional midwife' at opposing ends. Illustration of the model and discussion of how the developed model has answered the research questions were detailed in Chapter Eight. The implications of the key findings in this research are considered in the following section.

9.3 Implications and Recommendations

This thesis has extended the current theoretical knowledge of identity work by elaborating on the discursive practices professionals employ to legitimate their professional identity and the various strategies individuals use to negotiate their competing identities at work. It has also extended attention to the influences of the institutional forces on professional identity construction. More specifically, the findings of this study contribute to the body of knowledge on understanding the professional identity of hospital-based midwives in China. As introduced in Chapter Two, the importance of the midwife in childbirth has been seen in the recent midwifery initiatives in China. There are signs that contemporary Chinese midwifery is going through a rudimentary stage of transition with the revival of midwifery discourse. At this moment, this emerging theoretical model provides a number of possible implications for midwifery practice, education and policy which would facilitate the

exploration of effective operational processes for midwives in China to develop professionally.

9.3.1 Midwifery Practice

The development of the theoretical model offers a deep insight into how hospital-based Chinese midwives construct their professional identity in the contemporary maternity care system. It revealed midwives' struggles to fit into the current maternity care system whilst retaining their professional sense of the self. In order to address identity dissonance, articulation and explicit discussion of the impact of the structural influences – including the institutional, organisational and professional context – upon the process of professional identity construction are crucial. If midwives could locate themselves within the model, recognise what elements shape their professional identity and the various strategies that they adopt to negotiate themselves in practice, perhaps it would help them to better understand how the professional identity constructs and the contextual constraints impinge on their practice and so gain a better position to identify with their 'authentic' selves.

The findings indicated that midwives' everyday practices were struggling between their professional ideals and the institutional and practical demands of the maternity care system. Framing the struggles surrounding hospital-based midwives as the identity dissonance derived from the external and internal definition of the midwife defined between the work organisation and the midwifery profession is significant for clarification of what elements cause difficulties for midwives and shape their professional identity. Purkis (2006) has found that current midwifery practice in the UK is established within the framework of 'boundary practice' (Wenger, 1998: 114) between two communities of midwifery and medicine. Midwives' everyday practice in hospital settings appears to support the practice of 'medwifery' and internalises such a philosophy into the centre of professional identity. Findings in this study support Purkis's (2006) conclusion and further indicate that some of the midwife participants were not clear about the philosophy of midwifery because of their

'institutional position', since in China the direct-entry midwives are educated fundamentally through association with biomedical knowledge and the nurse-midwives were prepared in a hospital context where the medical-technocratic model of care is persistent. Even the midwives, who claimed the ideological concepts of being with woman and advocating normal birth as the keystones of their professional identity, often had to adjust their internal definitions of being a professional midwife to organisational management. As a result, some of the midwives seemed to be immersed in the system that is criticised by the service users (Cheung et al., 2005, Blumenthal and Hsiao, 2005) and by midwives themselves as revealed in this study. In order to address such immersion or what O'Connell and Downe (2009: 605) theorised as 'bad faith', explicit discussion of the political, organisational and professional influences upon professional identity construction and what the 'authentic' midwife means for individuals can enhance understanding and reflection, and facilitate possible meaningful changes. In addition, emotional distress (e.g. frustration and powerlessness) and risk concerns derived from the identity dissonance is strong in this research. There is also a need to support and encourage midwives to articulate the dissonance they encountered in daily practice in order to alleviate their emotional distress and enhance professional engagement.

In an investigation of Chinese midwives' views on a proposed midwife-led model, Cheung et al. (2009) argued that Chinese midwives are now making efforts to clarifying their roles. However, such attempts for role clarification require a platform. The existing professional development activities within each unit have created opportunities for communications and knowledge exchange amongst midwives, but are mainly based on the theoretical and practical knowledge learning, as midwife participants stated. There is no clear indication that such activities have enabled midwives to articulate the dilemma they encountered in everyday practice due to the conflict between their professional ideals and the nature of work settings and institutional imperatives. A number of studies in midwifery and nursing literature have demonstrated the benefits of clinical supervision for professional identity development through aspects of peer support, stress relief, professional accountability and

competence development e.g. (Ralston, 2005, Deery, 2005, Brunero and Stein-Parbury, 2008). For the situation of Chinese midwives revealed in this study, implementation of effective clinical supervision may be a solution for supporting midwives by encouraging them to reflect on their practice, to speak of their feelings of dissonance, and to share with, and gain support within, their professional group.

Moreover, this study has also addressed the theoretical assumptions regarding the issue that the development of an individual's professional identity evolves through engaging in activities of professional development (Ohlen and Segesten, 1998, Johnson et al., 2012). Although the periods of education and preparation also play an important role in the process of professional identity construction, it is evident that midwives have participated in a range of informal professional development activities which facilitated their understandings and clarifications of the essence of being a professional midwife, and enabled them to engage in their professional role in practice. Considering the marginalised status of contemporary Chinese midwifery, participation in activities of professional development will create opportunities for professional improvement and support midwives to develop professionally. The midwives' managers should create an environment for professional learning and practice (such as implementation of the midwifery model of care, evidence-based learning and practice, knowledge exchanges in and out of their community and self-reflection on practice) and provide opportunities for midwives to experience and reflect on the meaning and value of the practice.

Similarly, as findings in this study revealed, the discomfort that resulted from the contradictory ideologies between the midwifery profession and the maternity care organisations has been recognised by many hospital-based midwives in different countries (Hunter, 2004, Foley, 2005, O'Connell and Downe, 2009, Purkis, 2006). On the basis of Festinger's (1957) cognitive dissonance theory, this study employed Costello (2005) concept 'identity dissonance' to theorise this uncomfortable experience and identified the strategies that midwives adopted to reconcile this discomfort. This study suggests that within the

bureaucratic and medical-dominant hospital settings the midwives' experiences of identity dissonance are inevitable and will continue to exist, particularly for contemporary Chinese midwifery with its subordinate 'nurse' position in the maternity care system. Findings of this study have then provided the strategies that individuals identified for dissonance reduction.

As the whole hospital settings were dominated by the medical-technocratic model, all midwives were actually navigating the self in maternity care to incorporate aspects of both the definitions from midwifery discourse and organisational management in order to fit the maternity care system – while retaining their professional sense of the self. The construction of individual midwives' professional identities appears to be a process of dissonance reduction, involving a constant reconfiguration of the meaningfulness underlying their daily practice in order to reach a temporary state of comfortableness. For the majority of midwives, they tried to maintain both of the identities and learn to live with the dissonance. Those midwives settled on the work role when confronting practical demands, or medical-legal power was beyond their competence; while they sought to enact the professional role whenever possible. The emotional distress was undoubtedly evident when they settled on the work role and left their professional ideology aside 'for the moment', as Purkis (2006: 263) stated in her study:

Midwives established identities that both aligned with the community of practice and satisfied themselves. Many seemingly achieved this, but often not without some doubt or regret.

In addition, considering the current tense relationship between health-care professionals and service users (Blumenthal and Hsiao, 2005), one of the underlying reasons identified in this study is the discrepancy between the care needs of the service users and the current care organisation in the health-care system. As well as the invisible public image of midwives, the effective and reciprocal relationship with women – which demonstrates success of midwifery care (Kennedy, 2000, Lundgren and Berg, 2007) – seemed hardly to be established by the midwives in this study. For some midwives, detaching themselves from

professional ideology was considered a defensive way to protect them from being emotionally drained and potential legal issues, whilst others kept trying to make alliances with women to better negotiate with the organisation. At the heart of midwifery care there is no doubt that women have been playing a crucial part in the survival of the midwifery profession. The strategy of aligning with consumer groups to sustain and support the midwifery profession was evident in the success of midwifery development in many countries, such as the UK, Australia, Canada and New Zealand. For the clinical midwives in this study, making allies of women clients appears to be an important strategy for midwives to pursue their professional ideals and sustain their professional identity. Currently, the existing antenatal education programmes for pregnant women in some hospitals may facilitate midwives in being able to effectively build such alliances.

This study also identified that the workplace structure where midwives continued their learning through practice played an important role for midwives to understand their professional orientation and the practice of agency in care provision. For the midwives, who worked firmly in the medical-technocratic context without opportunities to access professional development activities, they were liable to be immersed in the work role without noticing the dissonance, while others who had experience of midwife-led care were likely to internalise the professional ideology and engage in shaping the organisational context. It again reflects the significance of professional development in midwives' professional identity construction, particularly the experiences of practising in a midwifery model.

Studies in other countries have uncovered that hospital-based midwives were well aware of the 'cultural inhibitions' for their professional identity formation (Kirkham, 1999, Purkis, 2006, O'Connell and Downe, 2009, Hughes et al., 2002), while 'constrained in many ways about how they feel they can address them' (Purkis, 2006: 267). By taking the perspective of identity dissonance and elaborating on the competing identities originating from the professional discourse and organisational management, I suggest this emerging model may

help midwives to clarify which elements of the 'cultural inhibitions' have triggered their identity dissonance. If midwives are able to identify themselves within the model and recognise the coping strategies they adopted, it may help them to get a better understanding of their professional orientation and the 'cultural inhibitions', and thus facilitate engaging in a practice that is consistent with their professional ideals.

9.3.2 Midwifery Education

The current midwifery education programme in China is primarily comprised of three or four-year courses in technical secondary school, whilst only a few were taught in the university with a midwifery direction based on nursing programmes. Some of the midwives trained in the early 1980s were prepared by quasi-obstetric modules. Recently, many of the qualified midwives are recruited from nursing graduates prepared via a form of on-the-job training in the workplace. In the light of the diverse routes for midwifery preparation and the role confusion revealed in the study, it is imperative to establish a distinct educational system for midwifery in order to regulate and promote quality of midwifery care.

Apart from the organisation of midwifery education, for the moment, one immediate solution to sustain a distinctive professional identity for midwifery would be a change in the content of teaching in the current midwifery programme. As the category 'medical preparation' suggested, the present midwifery preparation at school largely emphasised biomedical knowledge while understating the central values that underpinned the midwifery profession. Theory has been acknowledged as the foundation to forming professional identity, framework for practice and knowledge development (Halldorsdottir and Karlsdottir, 2011). The increase of and emphasis on the content of midwifery theories in the midwifery curriculum would help promote midwifery values and clarify student midwives' professional orientation. There is evidence in this study to suggest that the professional development activities (such as self-study on evidence-based midwifery knowledge and international communication) provided greater opportunities for midwife

participants to access midwifery discourse and reflect on their own practice. One feasible change might be an adjustment and update of the midwifery curriculum that presently references obstetrics heavily. Midwifery educators need to illuminate the theoretical basis for midwifery with reference to the existing theories that guide midwifery practice e.g. (Lehrman, 1988, Thompson et al., 1989, Kennedy, 2000, Downe et al., 2007, Downe, 2010, Halldorsdottir and Karlsdottir, 2011), continuously incorporating updated and evidence-based midwifery knowledge into the courses, and encourage students to make full use of the research database for self-learning and reflection. In addition, considering the divergence between the theoretical basis of the midwifery profession and the organisational reality in hospital settings, as evidenced in this study, an integration of theory and practice also needs to be contemplated during midwifery preparation, particularly through clinical placement. As suggested in Section 9.3.1, student midwives also need to be supported by effective clinical supervision during their clinical placement in order to prepare them for socialisation into midwifery practice without experiencing severe identity dissonance.

Furthermore, the post-professional education or continuing educational opportunities also need to be paid urgent attention to for the time being. As revealed in the study, despite the diverse educational preparation, both direct-entry midwives and nurse-midwives stated that the on-the-job training process has played a significant part for socialising them in maternity care. However, due to the organisational management in the work settings, such practice-associated learning has firmly framed midwives in a medical-technocratic module, wherein they are liable to be immersed in the task-oriented and risk-focused role of an obstetric nurse. Without a mechanism to support and promote the application of the central tenets for midwifery care (being with woman and advocating normal birth), midwives will be unlikely to initiate change within the hospital settings. Change can be effected when the profession makes efforts to create continuing educational opportunities for practising midwives and develop effective mechanisms to support midwifery ideals. The findings of this study indicated that midwives' tangible reflections and changes have been aroused by the informal professional development activities enlightened by the revival of midwifery

discourses. The most explicit example is evident in the coping strategies that the midwives in TGH used. Although a more systematic continuing educational programme is needed, the simplest kind of continuing education can be conducted in each maternity unit through clinical group supervision. It can provide opportunities for midwives to share evidence-based practice and reflect on current practice, and then make workable changes in their practice. Besides, midwives also accredited their professional development to the activities outside of their own community. The clinical manager could create more opportunities for midwives to exchange their knowledge and experiences with midwives outside of their own unit.

9.3.3 Midwifery Policy

This study attended to the influences of institutional forces upon professional identity construction. It has extended the understanding of midwives' professional identity construction from the one that generally concerns the constraints within organisational contexts (Purkis, 2006, Lane, 2002, Pollard, 2011) to the consideration of the impact from 'extraorganisational forces' (Chreim et al., 2007: 1516). Such institutional level analysis is particularly applicable to the study on professional identity construction of Chinese midwives, considering their nursing position in the maternity care system.

According to the category 'institutional position', the institutional constraints for midwives' professional identity construction is strong, as the 'medical preparation', 'role confusion' and 'invisible public image' that the institutional forces resulted in have led to the professional identity crisis for midwifery. The root cause of these problems is firmly related to current health-care policy, which has assigned midwifery to the broader nursing group and subsequently reconfigured midwifery preparation, redefined professional boundaries and made the image of the profession invisible to the public. This empirical study supports the existing arguments that have been concerned with the marginality of contemporary Chinese midwifery in relation to the professions of medicine and nursing (Cheung, 2009, Tan,

2010). Such an 'institutional position' has inevitably affected midwives' negotiation and enactment of their professional role in the workplace in terms of the acknowledgement and support from management, the professional autonomy under the authority of obstetricians, and the relationship with women. This study is thus important in raising awareness amongst policymakers and important stakeholders of the marginal status of midwifery in China and the impact of health-care policy on micro-level practices. In order to 'ensure high quality midwifery care for mothers and babies' (ICM, 2011b) and development for the profession, there is a pressing need to legislate for the independent professional status of Chinese midwifery. It requires the support of government policies to recognise the professional identity of midwives, develop a separate regulatory body to regulate the standards of midwifery practice to protect the public interest (ICM, 2011b) and establish a distinct education system to promote professional quality (Cheung et al 2005; Cheung 2007).

In the UK, midwifery is a distinctive profession (Borsay and Hunter, 2012) and the title midwife is officially recognised within legislation (Winship, 1996: 41, Kirkham, 1998, Department of Health, 2008). The statutory body of the Nursing and Midwifery Council (NMC) regulates and controls the standards for midwives' continuing professional development programmes, supervision and clinical governance (NMC 2008). Apart from NMC, there is also a separate professional body, the Royal College of Midwives (RCM), to support midwives in their jobs and promote their professional development (Cheung, 2011). For American nurse-midwifery, which shares similar institutional status as midwifery in China, it has: a midwife title (though hyphenated); the regulatory body North American Registry of Midwives for midwives who assist birth at home and its own organisational bodies (American College of Nurse-Midwives, ACNM) for education and standards of practice (Dawley, 2002, Rooks, 2007). While these international authorities are not without their deficiencies, Chinese midwifery may still learn from what these bodies have and have not achieved. In addition to raising government policymakers' awareness of the situation of Chinese midwifery, there is also a need to arouse the sense of leadership within the midwifery profession. It is time for midwifery to form its own professional association to

encourage midwives across different levels to share a sense of responsibility for the success of the profession and to maintain and enhance the professional development and support midwives.

As the importance of the midwives' role in childbirth has been seen in the recent midwifery initiatives in China (see Section 2.4.5), this developed theoretical model is wished to serve as a frame of reference for health-care policymaking and administrations in order to strengthen midwives' professional quality and power to play their roles in serving women and society.

9.4 Recommendations for Future Research

With regard to the potential limitations related to the methodology, some suggestions for future study have been discussed in Chapter Four (see Section 4.7). Considering the additional recommendations for future research in relation to this study, research might be conducted in other geographic areas across China and in hospital settings in rural areas to test if the findings are reflective of the views of midwives in other contexts.

In addition, the findings can also help to develop a survey tool to conduct a quantitative investigation across a large area in terms of midwives' views on the identity constructs and the impact of the institutional and organisational contexts upon professional identity construction.

Moreover, due to the identity dissonance, midwives in this study expressed high levels of emotional distress and risk concerns, which have driven them to making compromises within the organisational management. Particularly for the midwives who chose to detach themselves from midwifery ideology at work, the long-term implication of such compromises may lead to a certain degree of tendency for retention. Future qualitative

research is recommended to analyse the identity dissonance and its specific implications for retention.

Furthermore, in this study professional development activities were viewed as essential for midwives to progress towards the professional midwife end of the identity continuum. Regarding this, research might be conducted to further explore the content and forms of continuing professional education. Participatory action research strategies might be employed to engage practising midwives and midwife managers in exploring the organisation and content of clinical professional development that would enhance their professional competence and promote best practice in midwifery care; and to develop action processes to design the programme and implement it.

9.5 Conclusion

The origin for this research emerged from concern for the professional identity crisis of Chinese midwifery. Historical developments and the recent initiatives of midwifery in China have implied that consistent with the ICM Mission Statement (2008: 32), Chinese midwives are the 'most appropriate professionals for childbearing women in keeping childbirth normal'. Considering that Chinese midwives are currently experiencing a stage of rudimentary transition, the advocacy of the profession and the nature of midwifery care require them to clarify their theoretical basis and develop a distinctive professional identity. This thesis has explored and shed light on this area. Findings of this thesis have identified the ideological constructs that midwives used to define their professional identity, elaborated on the institutional and organisational impacts upon professional identity construction, revealed the identity dissonance that midwives experienced in everyday practice, and identified various strategies that individual midwives use to work on the identity dissonance. The developed theoretical model 'navigating the self in maternity care' has facilitated a deep understanding of how hospital-based Chinese midwives construct their professional identity in an effort to fit into the contemporary maternity care system

while not losing their professional sense of the self, which provided possible implications for the practice, education and policy of Chinese midwifery. Under current circumstances, the value in this research is expected to advocate action to establish an effective system that facilitates Chinese midwives to develop professionally. The findings of this thesis can serve as points of departure for such a significant venture.

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**APPENDIX A: SUMMARY OF KEY EMPIRICAL STUDIES ON THE
SUBJECTS OF 'MIDWIFERY' AND 'PROFESSIONAL IDENTITY'
INCLUDED IN SECTION 3.4**

Appendix A: Summary of Key Empirical Studies on ‘Midwifery’ and ‘Professional identity’ included in Section (3.4)

<u>Author:</u>	<u>Title:</u>	<u>Methodology:</u>	<u>Setting and Sample:</u>	<u>Key findings:</u>	<u>Contributions:</u>
Scoggin, 1997	How nurse-midwives define themselves in relation to nursing, medicine, and midwifery.	Two-phase mixed methods study. <i>Qualitative phase:</i> Semi-structured interview; <i>Quantitative phase:</i> Mailed questionnaire survey.	Nationwide study in the United States <i>Qualitative phase:</i> Purposive sampling 20 practicing nurse-midwives; <i>Quantitative phase:</i> Random sampling 300 nurse-midwives.	<i>Qualitative phase:</i> Nurse-midwives used the traditional midwifery ideologies of ‘advocacy, normalcy, competency, authority and autonomy’ to differentiate themselves from physicians and nurses; <i>Quantitative phase:</i> 1) Nurse-midwives identify occupationally with midwifery rather than nursing or medicine; 2) The variables that were most predictive of a positive midwifery occupational identity were: a) philosophical agreement with nurse-midwifery ideologies; b) increased years of nurse-midwifery practice.	The study implies that: 1) occupational identity is partly a product of how the whole occupation defines itself; 2) external cultural or social variables can exert a powerful force for change, pressuring nurse-midwifery to alter its identification with nursing; 3) nurse-midwifery is also changing internally.
Lane, 2002	Midwifery: A profession in transition	Qualitative study. In-depth	A regional Victoria in Australia Snowball sampling 22	1) Midwives ranged along a continuum with the two ‘pure’ models (midwifery and medical) at either end; 2) Each midwife constructed a unique set	1) This empirical study evidences the theoretical statements of DeVries (1993) and Van Teijlingen

		interview	midwives in a large public hospital, a large private hospital and the community.	<p>of practices shaped by her own lived experiences including where she works, the extent of her clinical experience, her training, her own birth and how she understands the medical model;</p> <p>3) Three types of midwives were identified: the 'obstetric-assistant', 'autonomous' and 'hybrid' midwife;</p> <p>4) In practice, few midwives fell into either the medical (obstetric assistant) model or the midwifery (professional, independent) model;</p> <p>5) Most midwives could be classified 'hybrid' in the sense that their clinical practice drew variously on each of the major discourses according to contextual factors;</p>	<p>(2005) that midwives are assumed to situate somewhere along a continuum between each model in practice;</p> <p>2) It further develops the theoretical statements of (DeVries, 1993) and (Van Teijlingen, 2005) by establishing that the ideological position of the individual midwife is a dynamic one, depending on the contextual factors.</p>
Foley and Faircloth, 2003	Medicine as discursive resource: legitimization in the work narratives of midwives	<p>Qualitative study.</p> <p>In-depth interview</p>	<p>State of Florida in the United States</p> <p>Theoretical sampling, 26 direct-entry, licensed midwives and certified nurse-midwives (including 5 practicing LMs, 4</p>	<p>1) Rather than placing the medical model in absolute opposition to the midwifery model, midwives were pragmatic in their approach, moving fluidly between the two models and employing the discourse of medicine as the source of their narratives of legitimization for the profession of midwifery.</p> <p>2) Midwives use the discourse of medicine</p>	<p>1) This work serves to document empirically the theoretical argument of Annandale and Clark (1996), who posit that both a discourse of midwifery and a discourse of medicine are constructed in relation to one another;</p>

			<p>direct-entry student midwives, 3 'retired' LMs, and 3 empirically trained midwives, 5 practicing CNMs, one student nurse-midwives, and 2 'retired' CNMs)</p>	<p>in three specific ways:</p> <p>a) drawing upon it as a contrast device, setting themselves and their work apart from the medical establishment;</p> <p>b) using the medical model to communicate necessary daily aspects of their work;</p> <p>c) constructing a story of medical collaboration to equate their work with that of physicians.</p>	<p>2) It indicates that the contemporary midwife is an agentic subject, capable of reflecting on her work and substantiating it through the discursive constructs available to her – midwifery and medicine.</p>
<p>Hunter, 2004</p>	<p>Conflicting ideologies as a source of emotion work in midwifery</p>	<p>A qualitative study using an ethnographic approach</p> <p>Three phases of data collection:</p> <p><i>Phase one:</i> focus group</p> <p><i>Phase two:</i> observation</p> <p><i>Phase three:</i> interview</p>	<p>South Wales in the UK</p> <p><i>Phase one:</i> self-selected convenience sample of 27 student midwives</p> <p><i>Phase two:</i> opportunistic sample of 11 qualified midwives</p> <p><i>Phase three:</i> purposive sample of 29 midwives working in one NHS Trust</p>	<p>1) Two primary occupational identities and ideologies were identified, based on the settings in which midwives worked;</p> <p>2) Hospital midwifery was dominated by meeting service needs, via a universalistic and medicalised approach to care; the ideology was, by necessity, 'with institution';</p> <p>3) Community-based midwifery was more able to support an individualised, natural model of childbirth reflecting a 'with woman' ideology;</p> <p>4) The conflict between the 'with woman' ideology and 'with institution' reality is associated to the emotion work in midwifery.</p>	<p>This research contributes to the studies on emotion work by identifying that the conflicting ideologies of midwifery practice is the key source of emotion work for midwives, particularly for the novice midwives (i.e. students and those who had been qualified for less than 1 year) and integrated team midwives.</p>

Hunter, 2005	Emotion work and boundary maintenance in hospital-based midwifery	<p>A qualitative study using an ethnographic approach</p> <p>Three phases of data collection:</p> <p><i>Phase one:</i> focus group</p> <p><i>Phase two:</i> Observation</p> <p><i>Phase three:</i> interview</p>	<p>South Wales in the UK</p> <p><i>Phase one:</i> self-selected convenience sample of 27 student midwives</p> <p><i>Phase two:</i> opportunistic sample of 11 qualified midwives</p> <p><i>Phase three:</i> purposive sample of 29 midwives working in one NHS Trust</p>	<p>1) For hospital-based midwives, negotiating the relationships with midwifery colleagues was a major source of emotion work, particularly between junior and senior midwives;</p> <p>2) This discord was underpinned by conflicting ideologies of midwifery practice;</p> <p>3) Midwives made use of a variety of devices in order to establish and maintain intra-occupational boundaries:</p> <p>a) senior midwives attempted to maintain their position through unwritten rules and sanctions, supported by their claim to greater clinical expertise and experience;</p> <p>b) junior midwives rarely challenged this authority; their responses were often subversive and designed to create an appearance of compliance.</p>	<p>1) The study employed the theoretical framework of boundary maintenance to interpret the findings;</p> <p>2) This research contributes to the studies on emotion work by identifying the ‘inter-collegial disharmony’ and the various ways senior and junior midwives used to establish and maintain intra-occupational boundaries.</p>
Foley, 2005	Midwives, marginality, and public identity work	<p>Qualitative study</p> <p>In-depth interview</p>	<p>State of Florida in the United States</p> <p>Theoretical sampling, 26 direct-entry, licensed midwives and certified nurse-</p>	<p>1) The marginality of this occupation lends itself to competing categories of identity that midwives must negotiate;</p> <p>2) In practice, the participants used ‘boundary negotiation’ as a tool to frame their identities;</p> <p>3) Their professional identity was</p>	<p>1) This research extends studies on identity work by identifying the complex discursive ways that midwives use history and the media as resources for boundary negotiation and</p>

			midwives (including 5 practicing LMs, 4 direct-entry student midwives, 3 'retired' LMs, and 3 empirically trained midwives, 5 practicing CNMs, one student nurse-midwives, and 2 'retired' CNMs)	constructed through a range of discursive practices that vary in the different contexts in which they practise, and in relation to different audiences; 4) Midwives are as likely to draw boundaries within categories of midwives as between different categories, e.g. licensed midwives, certified nurse-midwives, traditional midwives.	impression management in order to construct their public identity; 2) Besides the common boundary work conducted between occupations (midwifery and medicine), the study also revealed intra-group negotiation between different types of midwives.
Purkis, 2006	Beyond qualification: learning to be midwives	A mixed methods study <i>Quantitative phase:</i> questionnaire survey <i>Qualitative phase:</i> interviews and diaries	West Midlands in the UK <i>Quantitative phase:</i> Convenience sampling Questionnaire were completed by 88 midwives at the point of qualification and by 52 midwives in the follow-up survey one year later <i>Qualitative phase:</i> Purposive sampling 15 midwives interviewed at three stages throughout their	1) The development of identity for newly qualified midwives is involved in their transitional learning practice at the fairly narrowly prescribed, contested, yet firm boundaries of midwifery and obstetrics, which is termed as 'medwifery'; 2) These boundaries are simultaneously hierarchical, intra-professional and personal; 3) In practice, these boundaries are frequently unclear and rapidly changing, thus contribute to an unstable, frustrating and frequently challenging context particularly for newly qualified members	1) This thesis contributes to an understanding of the development, or lack of development, of midwifery practice at theoretical, conceptual and practical levels; 2) It defines a practice dominated by obstetric norms, and by extension offers a conceptualisation in terms of identity formation for newly qualified midwives. 3) Viewing practice as social learning offers a new

			first year of qualification; 5 of them kept a diary for one week	of the profession.	perspective on the opportunities and challenges inherent in the current model of care.
Rosenfeld and Foley, 2007	Working against the self: midwives, competing identities and burnout	Qualitative study In-depth interview	State of Florida in the United States Theoretical sampling, 26 direct-entry, licensed midwives and certified nurse-midwives (including 5 practicing LMs, 4 direct-entry student midwives, 3 'retired' LMs, and 3 empirically trained midwives, 5 practicing CNMs, one student nurse-midwives, and 2 'retired' CNMs)	1) Several sources of strain were identified – a) those embedded in the consequences of working outside of the medical model (customized and emotionally demanding patient care, on-call status, and immersion in clients' lives); and b) those embedded in the consequences of being positioned on the margins of the medical system (opposition from medical agents and institutions, problematic relations with backup doctors, difficulty obtaining liability insurance, and the lack of administrative resources and strictly defined work shifts); 2) Stress is a product of a conflict between midwives' own ideological mandate and their political and legal location on the fringes of the medical enterprise; 3) Coping mechanisms include embracing aspects of the medical model from which they ideologically disassociate themselves, suggesting that the political location of	This research contributes to the literature on stress by providing insight into the consequences of political and institutional marginalisation on the working lives of midwives, and by extension other alternative health care providers working under similar social, political, and legal conditions.

				midwives limits their ability to meet their self-declared professional commitments.	
Larsson, 2009	Professional role and identity in a changing society: Three paradoxes in Swedish midwives' experiences	Qualitative study Focus group interview	Labour ward of a Swedish University hospital in a medium-sized city Convenience sampling 20 midwives who had at least 20 years of working experience	Three paradoxes were emerged in this study: 1) decreasing professional role of the midwives related with other professions and increasing reliance on medical technology in childbirth comparing to better communication and collaboration with other medical staff; 2) strong professional identity derived from professional expertise including skilled handcraft and long experiences in contrast with growing insecurity in their professional identity and value because of increasing use of medical intervention and limitation of prescriptive guideline; 3) midwives are satisfied with humanised midwifery care and good relationship with childbearing women, while service users are more knowledgeable and more demanding which threatens midwives' professional competency.	The study contributes to the understanding of midwives' professional identity development by exploring the impacts of the changing social, political and organisational context upon identity construction.

APPENDIX B: CONTRASTING CHARACTERISTICS OF FIVE QUALITATIVE APPROACHES

Appendix B: Contrasting Characteristics of Five Qualitative Approaches (Creswell, 2007: 78)

Table 4.1 Contrasting Characteristics of Five Qualitative Approaches

<i>Characteristics</i>	<i>Narrative Research</i>	<i>Phenomenology</i>	<i>Grounded Theory</i>	<i>Ethnography</i>	<i>Case Study</i>
Focus	Exploring the life of an individual	Understanding the essence of the experience	Developing a theory grounded in data from the field	Describing and interpreting a culture-sharing group	Developing an in-depth description and analysis of a case or multiple cases
Type of Problem Best Suited for Design	Needing to tell stories of individual experiences	Needing to describe the essence of a lived phenomenon	Grounding a theory in the views of participants	Describing and interpreting the shared patterns of culture of a group	Providing an in-depth understanding of a case or cases
Discipline Background	Drawing from the humanities including anthropology, literature, history, psychology, and sociology	Drawing from philosophy, psychology, and education	Drawing from sociology	Drawing from anthropology and sociology	Drawing from psychology, law, political science, medicine
Unit of Analysis	Studying one or more individuals	Studying several individuals that have shared the experience	Studying a process, action, or interaction involving many individuals	Studying a group that shares the same culture	Studying an event, a program, an activity, more than one individual

APPENDIX C: INTERVIEW GUIDE

C1 Interview Guide for Midwife Participants

C2 Interview Guide for Women Participants

C1 Interview Guide for Midwife Participants

助产工作及选择助产职业的动机 Midwifery Practice and Career Motivation

能简要的介绍你下你现在的工作吗？

Open question: Can you tell me a bit about your current work?

- 你为什么选择做一名助产士？
- What motivated you to work in midwifery field?
- 可以告诉我，你刚从事助产工作时是如何看待助产士和助产工作的？
- Could you tell me what were your views of midwifery when you joined this area of work?
- 工作这么长时间后，你对最为一名助产士的看法有了什么样的变化？什么原因导致的这些变化？
- Are there any changes of your views of midwifery since you have worked so far? What causes such changes?

助产士身份的认知及工作经历 Perceptions of midwife identity and working experiences

- 你怎样看待助产专业？你认为助产士的本质是什么？
- What are your views on midwifery as a profession? /What do you think is the nature of being a midwife?
- 可不可以告诉我，在你的助产职业生涯中的哪些经历让你记忆犹新/对你来说非常重要（好的或者不好的）？可不可以具体描述一下？
- Could you tell me some significant events in your professional career (positive or negative)? What happened in these events?
- 这些经历如何影响你对自身助产工作/助产士身份的看法？
- Could you reflect on these events of the impacts on your identity? /How have these events shaped or informed your views on your own identity?
- 这些经历如何影响你对助产专业的整体认识（助产的专业化发展）？
- Could you reflect on these events of the impacts on your sense of professionalism?/How have these events shaped or informed your views on midwifery identity for the profession as a whole.

工作环境及与其他人员的互动 Working environment and interaction with others

- 你的工作环境怎样？
- What is the work environment in your organisation like?
- 你如何应对工作环境中一些不利助产工作开展的因素？
- How do you cope with the stressors which may result from your working environment?
- 你认为别人（产妇、产妇家人以及其他医务人员）是怎样看待助产士这个专业的，对你的助产工作有什么影响？
- How do you think midwife is perceived by others (mothers, families and other health professionals' views of midwives) and what impact does this have?

C2 Interview Guide for Women Participants

此次访谈旨在从产妇的视角了解助产士的社会形象及其功能。访谈以开放性问题开始：

The interviews address what women see as the image and role of the midwife. Interview starts with an open question about their encounter of midwife during childbirth:

- 可以给我讲一讲在你此次生育过程中，与助产士接触的经历吗？
- ‘Can you tell me about the encounter with the midwife/midwives during your childbirth? / Tell me what your experiences were when you encountered the midwife during your childbirth.’

通过采用探究性问题如“你当时的感觉怎样？”“可不可以再详细一些？”鼓励访谈对象深入描述她们的经历。

Probes such as, ‘How did you feel?’ ‘Could you tell me more about this?’ encourage the participants to add depth in describing their experiences. The woman is encouraged to describe all her feelings and experiences fully and without interruption.

鉴于一些产妇可能不清楚谁是助产士或者不清楚为她提供服务的是否是助产士，需通过以下问题进一步阐明：

In case that some women might not know clearly who is the midwife or whether the health professionals who cared for them are midwives or not, the following questions will be further formulated for clarification:

- 在此次怀孕前，你知道助产士是谁，她们在产科服务中做什么吗？（你是怎么知道的？）
- Do you know who midwives are or what they do in maternity care before your childbirth? (How do you know?)
- 在你孕期及分娩过程中有没有接触过助产士？（如果不确定，能和我简单描述一下在分娩期间照顾过你的医务人员吗？）
- Have you ever encountered midwives during your pregnancy and labour? (If you are not sure, can you describe the health professionals who cared for you during your labour?)
- 可不可以回忆一下，在你孕期或分娩过程中由助产士为你提供护理的场景（好的或不好的）？什么情况？
- Can you think about (positive or negative) situations when you experienced the care by midwives? What were the situations?
- 你认为助产士怎样做才能保证高质量的助产服务？
- Is there anything that you would like midwives to do in order to give good care to women?
- 在由助产士照顾和接生后，你是如何看待助产护理工作和助产士群体的？（如助产护理的意义，与助产士的关系）
- What do you think of midwifery care and the midwife after being cared by them? (Such as the meaning of midwifery care; the relationship with midwives)
- 关于本课题的研究内容，你认为还有什么要补充的？
- Is there anything else you would like to tell us that would help inform this project?

APPENDIX D: SAMPLE OF CODED TRANSCRIPTS

D1 Sample of Coded Transcripts (English Version)

D2 Sample of Coded Transcripts (Chinese Version)

D1 Sample of Coded Transcripts (English Version)

This appendix comprises the coded transcript of the interview conducted with midwife Emma. This was the third interview conducted in the overall process. The column to the right of the transcript lists the open codes assigned to the text.

Information of Recruitment			
Ways of Access		By Personal contact	
Sampling Reason: I have interviewed two midwives with managerial experiences, each with more than 20 years working experience in midwifery care. After analysing the two interviews, they reflected their personal development in the past 20 years and the development of midwifery from the managers’ perspective. The two midwife managers’ experiences revealed that midwives’ professional identity was constructed through their interpretations and reinterpretations of their experiences in midwifery care and influenced by the midwifery status in the wider institutional context. However, I found there were less details of the working episode or scene involved in these conversations. It maybe because they were in charge of the unit, it left them less time to undertake the clinical work, especially less opportunity to be there with their service users as their staff midwives did. To further explore how midwives construct their professional identity in their daily practice, I followed the theoretical hints to sample the midwives who do not have the managerial position and work directly in the forefront.			
Description of Interview			
Venue	Nurse lounge	Participants	Emma TGH
Demographic information			
Year of birth	1988	Gender	Female
Race	Han	Marital Status	Single
Educational characteristics			
Highest earned degree		Diploma in Junior College in Midwifery	
Original education and subject		Diploma in Junior College in Midwifery	
Years completed midwifery programme		2008	
Employment Characteristics			
Current employment		Full-time midwife	
Years in midwifery clinical practice		3 and a half year, including 1 year internship	
Years of working in this maternity unit		3 and a half year, including 1 year internship	

Translated transcripts	Open Codes
Emma: I graduated from a junior college with a four-year course in midwifery programme. It was considered as the highest-level midwifery programme at that time.	Graduated in midwifery major; direct-entry midwife Diploma in junior college is the highest level in midwifery programme

<p>Researcher: Could you tell me a little bit about the reason that you chose to be a midwife?</p> <p>Emma: I was only 16 when I took the midwifery course and had no idea of what midwife does. My parents made this decision for me. In their opinion, becoming a midwife means that I would have a stable job.</p> <p>Actually, even when studying in the college, I was not sure about what I was going to do and where to go in the future. Until working in the hospital for almost 2-3 years, I started learning more about midwifery and understanding midwifery work.</p> <p>I feel the knowledge learned in midwifery programme was too theoretical and conceptual. Much of the knowledge cannot be applied directly at work. We didn't have much opportunity to practise. I even didn't have the chance to see one baby delivery during my study. The sense of what midwives do was more developed when I started to work. Each new qualified midwife will be mentored by an experienced midwife at the beginning of our career. We followed our mentor during her shift and learned the clinical knowledge and skills from her till we were ready to do it on our own.</p> <p>Until now, compared to the midwives with more than 20 years' working experiences, I am still a novice.</p>	<p>Becoming a midwife is not personal choice</p> <p>Career stability is the motivation</p> <p>Unclear career path at school for career development</p> <p>Being socialised through on-job learning</p> <p>Gap between theory and practice</p> <p>Profession identity construction at school is based on theory</p> <p>On-job learning is the key pathway for professional identity construction</p> <p>Learning to be midwife through apprenticeship</p> <p>Feeling as a novice midwife</p> <p>Experiences enable professional identity development</p>
<p>Researcher: So, how do you feel the last 2-3 years' experiences of working in the maternity unit helped you to develop your understanding of midwifery?</p> <p>Emma: Actually, I feel very lucky to join in a midwife-led birth project at the beginning of my career. I was trained under midwifery model. It was a really different experience compared to my previous experiences in the traditional model (the obstetric-led model)...The traditional one is more risk-focused, while midwifery model emphasises the continuous and woman-centred care. Midwives play a key role rather than obstetricians.</p>	<p>Being trained under midwifery model</p> <p>Contrast feeling of being a midwife between two different models</p> <p>Being risk-focused in obstetric-led model</p> <p>Being woman-centred in midwife-led model</p> <p>Gaining professional autonomy in midwife-led model</p>

<p>Emma: When I worked in obstetric-led unit, I felt it is just a job for me, nothing special.</p> <p>Because we are not the leading professional, doctors always told us what we should do.</p> <p>There is only one major target. It is to control labour and keep it as fast as possible. Sometimes, we were formed an inertial thinking...‘Her contraction is not strong enough, do an artificial rupture of membranes’...This is our entire environment.</p>	<p>Considering midwifery care only as a job in obstetric-led model</p> <p>Obstetric model inhibits professional identification</p> <p>Subordinating to doctors</p> <p>Losing professional autonomy</p> <p>The faster, the better</p> <p>Internalising medical paradigm</p> <p>Routinised intervention</p> <p>Medical-oriented work structure</p>
<p>Emma: In this midwife-led care model, I’ve truly learned a lot. It emphasised the continuous and woman-centred care. Midwives play a key role rather than the obstetricians. I got to experience the meaningfulness of my work, the feeling that I might never experience in obstetric-led model.</p> <p>R: Like?</p> <p>Emma: Like...you know I am responsible to the whole family. When I was there, in the labour room with the woman and her family, I felt what they were feeling, the expectation, the love and the pain. Likewise, I got their respect, trust and reliance on me, feeling valued as being a midwife.</p> <p>In midwife-led room, we are careful of any unnecessary intervention, whatever medicine or technological intervention. We can be there with women for over 5 hours from their 2-3 centimetre dilation until after birth. Though we didn't have any contact or communications before they came into our unit, women showed their respect, trust and rely on us during their childbirth.</p>	<p>Identifying the meaning of being a professional midwife</p> <p>Midwife-led model facilitate professional identification</p> <p>Caring for the whole family</p> <p>Enabling mutual understanding and recognition</p> <p>Achieving the value of being a professional midwife from the feedback of service users (being verified by service users)</p> <p>Being discreet with intervention</p> <p>Being there with labouring woman continuously</p> <p>Facilitating rapport establishment</p>
<p>Researcher: So, what’s the difference of your work between midwife-led and obstetric-led model? How did such experiences of working in different model make you feel yourself as a midwife?</p> <p>Emma: In midwife-led model, we have time to communicate with women. We need good communication skills; otherwise it would be awkward</p>	<p>Facilitating communication</p> <p>Requiring good communicating skills</p>

<p>to be there with them for such a long time.</p> <p>We provided women with some skills to relieve the labour pain, like Lamaze. Though such skills were taught during antenatal preparation in the outpatient clinic, women felt they still couldn't use it well during labour. So we guided them during labour. We also talked with them throughout their childbirth. For example, we may ask their expectations of the baby and birth. It is a good way to build up rapport and make them relax through encouraging them to express.</p> <p>We also gave them massage and provided the care women need. We listened to them and truly cared for them. They can feel our sincerity. As a result, successfully establishing good relationship with women brought sense of achievement to us.</p>	<p>Providing non-drug pain relief skills</p> <p>Intrapartum support is needed</p> <p>Guiding women through labour and birth</p> <p>Encouraging disclosure</p> <p>Facilitating rapport</p> <p>Providing individualised midwifery care</p> <p>Sincere presence and support</p> <p>Good relationship with women is the source for Professional achievement</p>
<p>Emma: However, in obstetric-led model we don't have enough midwives to be there for women. Totally, there are 42 midwives in our unit. Excluded those on wedding or maternity leave, only 38-39 are on job. Even based on the standards of nurse/bed ratio in China, we are far from enough, let alone compared to the midwife/birth ratio standards in other developed countries.</p> <p>The nurse managers think there is nothing special for midwives' work or to be a midwife. When the medical, surgical department and the maternity unit are all short of staffing, the medical or surgical department would certainly get attention and staffing support from the administration. This is the whole concept from the top down. It takes time to change.</p> <p>Truly, you can hardly imagine the situation at night shift. On the day shift, there are usually 7-8 midwives, but at night only 3. If you need to take care of 7 or 8 labouring women at night, it is impossible to give sufficient support and care. We can only focus the physical safety of the mother and baby, no accidents.</p> <p>We spent too much time on paper work, recording notes. It compromised the time for women. Usually we have to care 3-4 women altogether, after the</p>	<p>Unable to provide one-to-one care to women</p> <p>Midwife shortage at work</p> <p>Problematic standards for midwife staffing allocation</p> <p>The midwives' role is undervalued by nursing management</p> <p>Lack of support from administration at workplace</p> <p>Restricted care to women, particularly at night shift</p> <p>Only Affording basic care</p> <p>Focusing on physical safety</p> <p>Paper work compromise time for women</p> <p>Being bound by technical work</p>

<p>basic technical work, like monitoring, recording or examining, there is very little time left. Most of our time is used to complete our basic task, keeping the birth safety.</p>	<p>Limited time to support women</p> <p>Being task-oriented</p>
<p>Emma: Under such circumstance, there were increasing complaints from service users, such as ‘You didn’t care for me... No one there for me...’ The relationship between women and healthcare professionals is really intense. Women are discontent with our service. Normally they didn’t say anything until after birth. You see, there is grumble there. If we can spend some time to communicate with them, encourage them to speak out their thoughts and discontent, there may not be so many complaints and disputes.</p>	<p>Being complained of leaving women there alone</p> <p>Less availability for women</p> <p>Tense client-professional relationship</p> <p>Women’s dissatisfaction with care</p> <p>Lacking time to encourage women to disclosure</p> <p>Provoking disputes</p>
<p>Emma: In midwife-led model on the other hand, we can relatively get more understanding (from service users), because we provided one-to-one care. We informed women the progress of their labour, encouraged them and demonstrated the labour process with pelvic model. When they understood each step during their labour and birth, they felt sense of control. We also let them know there is the possibility that the baby couldn’t come out. It maybe the Cephalopelvic disproportion.</p> <p>See, as long as we can be there for them during the whole labour process, providing sufficient information and support, women became more engaged in the birth process. Even though something unexpected happened, they knew we have done, they understood.</p>	<p>One-to-one care facilitating mutual understanding</p> <p>Continuous information support</p> <p>Empowering women</p> <p>Preparing women for unexpected outcome</p> <p>Women became more engaged</p> <p>Being with woman facilitates mutual understanding</p> <p>Increasing service users’ satisfaction</p>
<p>Researcher: How did you feel about yourself after working in that midwife-led room?</p> <p>Emma: I feel I can become the midwife I expected to be, but sometimes I feel helpless.</p> <p>Researcher: helpless?</p> <p>Emma: Doctors intervene in the whole unit, even in midwife-led labour room. When the labour was prolonged or contraction became weak, they came in and gave prescription. Interventions such as oxytocin</p>	<p>Becoming the expected professional self</p> <p>Feeling helpless</p> <p>The whole working environment is still obstetric-led</p> <p>Doctors have the authority to intervene</p>

<p>would be given.</p> <p>After spending time and making efforts to take care of women, they just stepped in. I feel losing my power. How to put it. It affected my confidence in supporting normal birth.'</p> <p>But you know it is always very encouraging when women hold their beliefs in normal birth after being cared by us. Being supported by our care, I've seen some women asked doctors to give them more time before intervention. You know, whatever the doctors want to do, they should respect women's own will. In these cases, I felt what I have done is worthy.</p>	<p>Doctors stepping in midwifery care</p> <p>Feeling disempowered</p> <p>Decreasing self-perceived competence</p> <p>Sense of achievement derived from successfully advocating normal birth</p> <p>Making allies with women</p> <p>Increasing self-worth</p>
<p>Researcher: Can you share your opinion with the doctors?</p> <p>Emma: It is hard to have equal communication with doctors, especially for a new qualified midwife.</p> <p>We need to learn more not just from experiences but also more up to date knowledge.</p>	<p>Equal communication with doctors depends on experiences</p> <p>Feeling disempowered in the interactions with doctors</p> <p>Less experience, less professional competitiveness</p> <p>Seeking 'up-to-date' midwifery knowledge for support</p>
<p>Emma: The risk underlying our work is another reason that prevented us from applying the value of normal birth into practice.</p> <p>You know, our work involves unexpected accidents, such as shoulder dystocia, clavicular fracture and perineal laceration. Once there is any accident happened to us, the consequence will be severe. It can destroy our confidence and even affect our career.</p>	<p>Risk underlying midwifery practice</p> <p>Risk concerns prevent midwifery practice</p> <p>Being cautious because of the uncontrollability of childbirth</p> <p>Being anxious of the consequence of adverse outcomes</p>
<p>Researcher: Did any of these incidents happen to you during your practice?</p> <p>Emma: Yes, three degree of perineal laceration, twice.</p> <p>Researcher: how did it affect you?</p> <p>Emma: It was so awful. It is still under investigation now. I am scared of delivering baby now. I have no idea what would happen to me. Because of my</p>	<p>Experiences of malpractice</p> <p>Losing self-perceived competence</p>

<p>incident, my colleagues start to use episiotomy routinely again.</p> <p>Although usually it won't go to court, the poor outcome might cause lifelong suffering to us. We feel disgraced, being criticised, judged. It can crush our confidence and we may even lose our job.</p>	<p>Affecting the work ethos in the unit</p> <p>Being anxious of the consequence of adverse outcomes</p> <p>Fear of the organisational sanction</p>
<p>Researcher: Is there anything else you would like to tell us that would help inform this project?</p> <p>Emma: We need more updated knowledge and skills to equip ourselves. However, We couldn't find such information in the bookshops or on the general websites. This is absolutely a restriction for our development. If we could bring in the up-to-date knowledge from the Western countries where the midwifery is well developed and adapt this knowledge into our context, it can become our leverage and help to promote our profession.</p>	<p>Needs for professional development</p> <p>Lack of source for professional development</p> <p>Needs to learn midwifery essence from the communities outside of China</p> <p>Desire to promote the profession</p>

D2 Sample of Coded Transcripts (Chinese Version)

Original Transcripts	Open Codes
<p>Emma: 我是专科，4 年的助产大专。她们说也是当时助产方面比较高的学历了。</p>	<p>助产专业 大专是助产最高学历</p>
<p>Researcher: 可以告诉我，当时为什么选择助产专业？</p> <p>Emma: 父母给选的。那时候年纪比较小，才 16 岁，不大了解这个行业具体是做什么的。整个来说，我母亲和我父亲觉得助产还是比较好的。觉得这个环境无论是对个人发展，还是说整个工作环境都是比较有前景的。通俗一点说不会以后没饭吃。</p> <p>实际上，我在学校里面也不是很清楚，将来一个发展方向，到底是怎样？不知道。直到参加工作两三年后，才慢慢有了体会。</p> <p>我觉得我们学的东西太理论化。和临床根本搭不上。因为我们操作的机会太少了。甚至都没有真正见过一个分娩的过程，学习的时候。所以说，其实很多这些工作和技能都是在工作后才接触。工作刚开始，每个新人都会由一个老助产士带着。跟着她值班，学习助产相关的知识和技术，一直到我们能够独立当班。</p> <p>直到现在，比起她们 20 多年的那种，我还是个初学者。</p>	<p>选择助产非自己的意愿</p> <p>职业稳定性是择业动机</p> <p>在校期间职业发展的迷茫 在工作中体验助产</p> <p>理论与实践的差距 在校期间专业身份建构基于理论学习</p> <p>在职学习是专业身份建构的主要途径</p> <p>感觉是个初学者 助产经验促进专业身份发展</p>
<p>Researcher: 那，你感觉过去两、三年的工作经历，对你对助产的理解起到了什么样的作用？</p> <p>Emma: 其实，我觉得我是挺幸运的。刚刚参加工作以后就参加我们科‘以助产士为主导的产房’这个的项目，在这个项目中培训。这种体验和我原来在普通的产房里面，或者说普通的岗位上面的体会是完全不一样的。在普通产房里，医生是主导，关注的是如何避免分娩中的风险。而在‘以助产士为主导的产房’，我们是主导。能给孕产妇提供连续的、以她们为中心的护理。</p>	<p>受到以助产士为主导模式的启发</p> <p>两个模式中助产体验的反差</p> <p>以医生为主导模式强调规避风险 以助产士为主导模式以产妇为中心 在以助产士为主导模式下获得专业自主权</p>
<p>Emma: 我觉得如果你是在普通产房参加工作，可能就觉得仅仅这是一份工作而已，然后没有非常深刻的体会。</p>	<p>在以医生为主导模式下，仅把助产当做工作 以医生为主导模式阻碍专业认同</p>

<p>因为不是你做主导，医生时刻都会提醒你，你应该做什么。</p> <p>反正目标只有一个，早点让她生出来。越快越好。有时，让我们形成了一种惯性思维：“这个人宫缩不好，赶紧给她破个水...”就是这么一个大环境。</p>	<p>从属于医生 失去专业自主权</p> <p>越快、越好 医疗模式内化 干预常规化</p>
<p>Emma: 我觉得在‘以助产士为主导的产房’工作后，我学会了很多。在这里，助产士发挥主导而不是医生。我真正体会到了很多在普通的产房里面，或者说普通的岗位上面体会不到的感觉。</p> <p>Researcher: 比如说？</p> <p>Emma: 比如，真的是，因为我面对的是一个家庭。面对着这个家庭，面对着夫妻两个对宝宝的一种期待，包括她们之间这种感情，还有这种痛苦。同样，我也能感觉到产妇对我很尊重，非常信任我，非常依赖我。让我感觉自己的价值。</p> <p>在‘以助产士为主导的产房’里，我们一般不主张干预，不管是人工的还是药物的。我们一般都会陪伴产妇 5 个小时以上，2-3 公分开始，一直到分娩结束。那么虽然说前期没有过很多的交流，但是你能感觉到产妇对你很尊重。非常信任你，非常依赖你。</p>	<p>感知作为助产士的意义</p> <p>以助产士为主导模式促进专业认同</p> <p>照护整个家庭</p> <p>促进相互理解和认可 感知作为助产士的价值</p> <p>审慎干预</p> <p>持续陪伴</p> <p>促进信任融洽关系的建立</p>
<p>Researcher: 那么，在以助产士为主导的模式和普通产房的模式下，你们的工作内容有什么不同呢？这会让你对自己，作为一个助产士，的认识有什么不同呢？</p> <p>Emma: 在‘以助产士为主导的产房’里，我们有时间和产妇进行交流。这也需要我们有较好的交流能力。要不然，没有前期的接触，4-5 个小时和她呆在一起，毕竟不熟悉，有尴尬的局面。</p> <p>我们通过一些减痛的技巧，拉马泽呼吸，就是根据你的节奏走的。虽然说我们这边妊娠期 7-8 个月就开始上课了，但事实上真正运用的很好的是很少的。所以到那个时候，你能给她喊节奏啊，和她说话呀，聊聊她对宝宝的这种期待，包括她对自己分娩的一种想法。鼓励她表达。通过这种方式拉近</p>	<p>促进沟通 要求沟通技巧</p> <p>提供非药物减痛知识</p> <p>产时支持的必要性</p> <p>产时对产妇的引导 鼓励产妇表达想法</p>

<p>我们之间的距离，让她放松。</p> <p>然后就是在交流过程中给她按摩，问她怎么舒服，她喜欢哪种我们就采取哪种方式。其实觉得只要真心对她，她能够感觉得到这种感受。这样一来，我们能够和她们建立良好的关系，同时也会增加我们的成就感。</p>	<p>促进融洽关系</p> <p>提供个体化助产护理</p> <p>真心的陪伴和支持</p> <p>融洽的护患关系是专业成就感的来源</p>
<p>Emma: 但是在普通产房，我们条件不允许。人员不够,真的不够。在岗的是 42 个人.但是有婚假产假这种，除掉以后可能 38-39 个在上班。但是如果按,医院,包括我们，不是国外的，国内的这种床位比例安排来看我们都是远远不够的。远远不够，真的。</p> <p>护理部对咱们也没有感觉到你的工作的特殊性。他们更重视大内、大外的发展。如果、内外科和产科都人手不足，护理部肯定会先调配人手到内、外科。所以说，从上到下整体观念都是这个样子的。要改变的话，需要时间。</p> <p>夜班简直难以想象。白班的话因为上班人相对多些,7-8 个上班。夜班 3 个人上班。你如果保证 7/8 个分娩，很难做到更多的支持和护理。只能说保证不出意外，真的...这就是我们现在面临的状况。</p> <p>其实我觉得我们大部分的时间都花在了记录上面，而忽略了对产妇本身的那种关心。就比如说，我们一般不会只面对一个产妇。我们同时会面对 3-4 个。我们要监控、记病程、检查。所以说等我把这些都弄好，一般宫口也开了。所以说，我们大部分时间都在做别的工作。完成个人职责。我们只是避免意外事故的发生。</p>	<p>无法提供一对一护理</p> <p>在职助产人员不足</p> <p>助产人员配比不当</p> <p>护理管理层低估助产士功能</p> <p>在工作场所缺少管理层的支持</p> <p>夜班助产服务受限</p> <p>仅能提供基本护理</p> <p>助产工作仅限于保障妇儿身体安全</p> <p>文件记录剥夺了助产士陪伴产妇的时间</p> <p>被基础技术工作束缚</p> <p>为产妇提供支持的时间受限</p> <p>以任务为中心</p>
<p>Emma: 在这种情况下，普通产房的怨气很大的。觉得“我在产房你就是不管我啊”。现在这种护患关系是很紧张的。然后她会怨恨，这不好那不好，但是她不说出来，她不和你明指。如果你能明显的指出来，所以有时候再跟产妇谈话的过程当中,真的希望我们每个人都能抽点时间跟她好好交流一下，鼓励她说出她的想法和她的委屈，或许她就没有那么大的怨气了。导致最后很多都是纠纷。</p>	<p>因不能连续陪伴被产妇投诉</p> <p>紧张的护患关系</p> <p>产妇不满助产服务</p> <p>缺少时间鼓励产妇表达其不满</p> <p>引发纠纷</p>
<p>Emma: 如果在‘以助产士为主导的产房’，相对</p>	<p>一对一服务促进相互理解</p>

<p>就能取得理解。因为我们是一对一的。我基本上都是在她边上，和她交流，告诉她进展，骨盆给她演示一下。哦，她就知道原来是这么个过程，有了控制感。如果在温馨产房，她每走一步，你和她解释一下，她就很理解，原来宝宝都最后也可能生不出来。她转歪掉了。它径线有问题，或她骨盆限制了，也不行。</p> <p>你看，只要我们能够在产妇旁边，提供连续的支持和护理，产妇就更容易配合，参与进来。即使最后有些意外情况，产妇和家属一般也能够理解，因为他们知道你做了什么，有些事你不能决定的。</p>	<p>连续信息支持</p> <p>赋予产妇权利</p> <p>解释可能出现的结局</p> <p>增进产妇配合参与</p> <p>促进相互理解</p> <p>提高服务对象满意度</p>
<p>Researcher: 那在这个模式下工作后，你對自己，作为一名助产士，有什么感觉？</p> <p>Emma: 我感觉我可以成为那个我期待中的助产士。但是有时候也是无能为力。</p> <p>Researcher: 无能为力？</p> <p>Emma: 医生会干预。‘以助产士为主导的产房’也会。因为这个病人要归她管，她当然要过来看看怎么样。如果说产程停滞了，宫缩弱了，她们医生过来查房的都会关注这些问题，‘啊，开药，上药...’真的。</p> <p>在陪伴产妇这么久后，被医生干预了。有一种权利丧失的感觉。这种事，怎么说呢。。。感觉信心会受损。</p> <p>但是，现在有一部分产妇就形成了自己一种独立的思维。在进入‘以助产士为主导的产房’后，就是希望宝宝能够平安正常的分娩，不希望出现任何的干预。她们能够和医生去交流，比如说“再观察2个小时行不行，如果实在不行，那么我们再做处理。”你看，医生毕竟也要尊重产妇的意见。在这种情况下，我真的感觉我的工作有了价值。</p>	<p>做期待中的助产士</p> <p>感到无力</p> <p>整体环境仍是医生主导</p> <p>医生有权干预</p> <p>医生干预进来</p> <p>感到权利丧失</p> <p>专业胜任感下降</p> <p>成就感源于成功促进正常分娩</p> <p>与产妇结成同盟</p> <p>提高自我价值感</p>
<p>Researcher: 你感觉能够和医生沟通吗？</p> <p>Emma: 平等的沟通还是有困难，特别是对于年轻的助产士。</p>	<p>与医生互动中权力不等</p> <p>缺少经验，缺少专业竞争力</p>

我觉得不只是经验，我们还需要更多的知识，坚定我们的想法。	寻求最新的专业知识支持
<p>Emma: 还有就是一些风险因素，很多正常产的理念我们没办法实现。</p> <p>在我们工作中经常会发生一些意外事故，肩难产、锁骨骨折，或者是会阴裂伤。在我们这里会阴裂伤比较深的话，算医疗事故。那么这个会直接影响你个人的一个发展。所以这种事情会比较，对你的心灵会一次次的撞击。</p>	<p>助产工作中的潜藏风险</p> <p>因潜在意外风险变得谨慎</p> <p>对潜在意外风险的结局感到焦虑</p>
<p>Researcher: 在你的身上发生过这样的事情吗？</p> <p>Emma: 有的，我发生过两个三度裂伤。</p> <p>Researcher: 对你有什么样的影响？</p> <p>Emma: 害怕，非常害怕，甚至害怕接生。现在她还没有出院。事情还在调查中。我们科室大家都不敢保了。而且现在侧切率又高上去了。</p> <p>尽管一般不会告上法庭，但是这种情况，说真的对我的影响都会很大，不管是心灵上的还是事业上的压力，都会很大。会感觉很丢人，感觉别人会评价你的技术。有的人就因为这个事情离开了科室。</p>	<p>发生医疗事故的经历</p> <p>失去专业胜任感 影响科室整体工作精神</p> <p>对潜在意外风险的结局感到焦虑 害怕医院的处罚</p>
<p>Researcher: 关于本课题的研究内容，你认为还有什么要补充的？</p> <p>Emma: 我需要最新的理念和技能来武装自己。书店里没有这方面的非常专业的书籍。国内很少的。网上一般的网站也找不到的。这是一种限制。如果我们可以将西方的一些新知识、新理念引进来，变成我们自己的东西，那就是特色，就是特点，做得好，以后就是口碑，能让助产得到认可。</p>	<p>需要专业发展 缺少专业发展资源 需要吸取西方国家助产知识的精华</p> <p>促进专业认可</p>

APPENDIX E: AN EXAMPLE OF THE DEVELOPMENT OF A CONCEPTUAL CATEGORY - ('REDUCING THE RISK')

Appendix E: An Example of the Development of a Conceptual Category - ('Reducing the Risk')

This appendix uses the conceptual category 'reducing the risk' as an example to demonstrate the development of a category in the coding process from the raw data, open codes to the category at focused coding stage.

Translated Transcripts	Open Codes	Focused Codes	Conceptual Category
<i>‘The principle here is “the faster, the better”. (Nurse-midwife, Juliet (TMH))</i>	The faster, the better	Working under Medical Protocols	
<i>‘There is only one major target. It is to control labour and keep it as fast as possible.’ (Direct-entry midwife, Emma (TGH))</i>			
<i>‘Her contraction is not strong enough, do an artificial rupture of membranes. ... This is our entire environment.’ (Direct-entry midwife, Emma (TGH))</i>	Routinising medical intervention		
<i>‘However, here, if you find the contraction becomes weak, oxytocin will be given right away.’ (Nurse-midwife, Lena (TMH))</i>			
<i>‘I know if we can be patient and wait and let women walk and move, the contractions would accelerate naturally. In our unit, however, speeding up is routine.’ (Nurse-midwife, Juliet (TMH))</i>	‘Speeding up is routine’		
<i>‘In our practice, the length of normal labour and birth is prescribed by the hospital protocols and the midwifery textbooks. The process of labour and birth is divided into three stages. There are strict time parameters for each one.’ (Direct-entry midwife, Catherine (TGH))</i>	Birth by clockwork		
<i>‘If considering the quality of care for clients, actually many of the interventions are unnecessary.’ (Nurse-midwife, Fiona (TGH))</i>	Over-interventions for women		
<i>‘Basically, we have no power to reject their medical orders. They are the decision makers. We are more like the followers.’ (Nurse-midwife,</i>	Doctors have authoritative power		

Maya (SH))		professional	Reducing the risk
'We are not the leading professional in childbirth, doctors are. They constantly remind us what to do. I am keen of keep childbirth as natural as possible, but they intervene. I feel helpless'(Nurse-midwife, Mary (TMH))	Feeling disempowered under doctors' supervision		
'We [doctors and midwives] don't have much intersection in terms of authority. They are entitled to supervise us.' (Nurse-midwife, Yvonne (TGH))	Being legitimately supervised by doctors		
'However, it seems like that we should behave as the obstetricians' assistants, passively following their orders' (Direct-entry midwife, Jenny (SH))	Feeling as obstetricians' assistants		
'She [the doctor] stepped in and managed the labour in her way. It was frustrating. I felt like I was losing power.' (Direct-entry midwife, Daisy (TGH))	Feeling frustrated by doctors' intervention		
'I've planned to give birth by myself and I know it is better for my baby. But, many of my friends and the people I know give birth by surgery.' (Woman, Joanna)	Being influenced by the medicalised birth culture	Women's Reliance on Medicalised Birth	
'The pain seemed to last forever. I couldn't stand it anymore. I just needed something to end it. Even though I know it is good for us to have normal births, I'd rather take the caesarean. After all, they are not that bad.' (Woman, Natalie)	Seeking medical intervention to conquer the labour pain		
'Most of the time midwives came to me was for injections or foetus monitoring ... the pain was killing me, but no one was there ... I felt really lonely ... I'd rather end this suffering by any means. So, I asked for surgery.' (Woman, Sophie)	Seeking medical intervention to end up going through labour alone		
'We know she was going through a tremendous event and she thought	Being caught in a		

<i>a caesarean can help terminate her suffering quickly. However, we also know there are many side effects of a caesarean. Also, her condition was fine, not included in the criterion for a caesarean. However, she insisted on surgery and so did her family.'</i> (Nurse-midwife, Fiona (TGH))	dilemma		
<i>'However, things are not always what we expect. There may be something wrong during childbirth.'</i> (Direct-entry midwife, Emily (TMH))	Things might go wrong	Risk Concerns	
<i>'Although usually it won't go to court, the poor outcome might cause lifelong suffering to us. We feel disgraced being criticised, judged. It can crush our confidence and we may even lose our job.'</i> (Direct-entry midwife, Emma (TGH))	Being anxious of the consequence of adverse outcomes		
<i>'This is the protocol for our practice. The length of the labour is rigorously defined. If we attempt to extend it and there is something wrong during childbirth, you couldn't justify yourself in the legal dispute, right? You know ... this is the reality we must face.'</i> (Midwife, Fiona (TGH))	Fear of litigation if not following the medical protocols		
<i>'I have been in pain for such a long time. I can't do it anymore. I need surgery... If you don't give me a caesarean, you must be prepared to take responsibility for any bad outcomes.' This is the scenario that happens almost every day in our work.'</i> (Nurse-midwife, Mary (TMH))	Fear of litigation due to women's occasional confrontations for the 'perfect outcome'		
<i>'Nowadays, clients perceive themselves as consumers. As long as they pay for the service, we should provide them with perfect care, perfect outcomes ... but you know, no one can guarantee the perfect.'</i> (Direct-entry midwife, Ellen (TGH))			

APPENDIX F: AN EXAMPLE OF MEMOS – FOCUSED CODE ‘RISK CONCERNS’

Appendix F: An Example of Memos – Focused Code ‘Risk Concerns’

'Risk concerns' emerged in all the conversations with midwife participants as one of the identity dissonance that midwives encountered in their everyday practice. 'Things might go wrong' is the common risk concern underlying midwifery practice, as indicated in Emily's words 'the stress that midwives have to work under', but the intensity of this stress varies. Further analysis revealed that there were a range of meanings in relation to this focused code, depending on the work environment; midwives' self-perceived competence; their past adverse experiences; the regulation of the obstetric protocols and hospital norms; and the consumerist pressures from the women clients.

Working in the hospital settings dominated by the medical model, midwives' concerns of the 'risk' (things might go wrong) were evident. Midwife Anne (SH) emphasised that 'Underlying the seemingly normal process, there are many abnormally risk factors. Sometimes, it can suddenly change into a crisis. For the mother and baby, I would say every minute counts.'

Midwives in the tertiary hospitals (TMH and TGH), where the high risk women were usually transferred to for medical treatment, mentioned that the stress underlying the unpredictability of childbirth was often heightened in such environment. Mary said that the emergent incidents were not sporadic in such work settings, which sometimes led to their anxiety when assisting normal childbirth.

Newly qualified midwives, such as Lena with midwifery experience under three years, revealed that lack of perceived competence intensified their risk concerns. They 'keep replaying every scene of their practices in their mind after work' to see 'if everything that they have done had no mistakes.

The past experiences of the adverse event and the consequence it may cause resulted in midwives' increasing cautiousness of the risk when assisting normal birth in the medical-legal system. Jessica recalled one accident, 'I encountered one incident several years ago. At the time, the woman's condition was quite normal. After ten hours' labour, she started to give birth.

During birth, however, a bad tearing happened. The woman and her family sued me for medical malpractice. This incident almost ruined my career.'

The focused code 'risk concerns' linked to the focused codes 'birth by clockwork' and 'speeding up is routine' which are defined as organisational norms by the medical professionals. As parts of the medical system, midwives raised a sense of powerlessness under these medical protocols. As Juliet spoke out, 'if not following the rules', they had to 'take responsibility for any poor outcomes on their own'. It implied that, despite midwives' professional knowledge and skills, their autonomy is restricted by the medical norms. Any violation of such norms may hint at the adverse consequences in the medical legal system.

The focused code 'risk concerns' is also related to the focused code 'women's reliance on medicalised childbirth'. The risk concern in relation to assist normal childbirth can be aggravated by the social expectations of the outcome of childbirth. Midwives raised the issue of the consumerist pressure on maternity staff in terms of women's request for medicalised childbirth, particularly caesarean section. The confrontation from service users in terms of being asked 'to guarantee 100% safety of mother and baby' (Mary); complains as 'we asked for surgery at the early stage, but you persuaded us to give birth on our own...now you told me I can't do it...' (Jessica) constantly challenged the midwives' professional ideology of advocating normal birth.

These risk concerns generated either internally (self-perceived competence, past adverse experiences) or externally (work environment, organisational norms and consumerist pressure) were the source of midwives' identity dissonance in relation to the competing ideologies under midwifery practice (reducing the risk or advocating normal birth). In this sense, whether the midwives' own ideology of practice matches the ideology in their work organisation and their clients' attitudes towards childbirth is the cause of identity dissonance to the midwives and may lead to subsequent behavioural responses.

APPENDIX G: SUMMARY OF THE CODING PROCESS

Appendix G: Summary of the Coding Process

This appendix provides a summary of the coding process, showing a link from the development of the focused codes to the conceptual categories at focused coding stage, and to the refined categories at axial coding stage.

Focused Coding		Axial Coding
Focused Codes	Conceptual Categories	Refined Categories
Medical preparation	Medical preparation	Institutional Position
Role confusion	Role confusion	
Invisible public image	Invisible public image	
Midwife shortage at work	Focusing on the task	Organisational Management
Working on an assembly line		
Women’s dissatisfaction with care		
Emotional distress		
Working under medical protocols	Reducing the risk	
Obstetrician is the leading professional		
Women’s reliance on medicalised birth		
Risk concerns		
Being with woman	Being with woman	Professional Discourse
What is normal	Advocating normal birth	
Professional in normal domain		

Focusing on the technical tasks	Settling the self on the work role	Compromising Strategies
Acquiescing in the medical protocols		
Disengaging the self from the caring role	Detaching the self from midwifery ideology	
Handing over responsibility to the obstetricians		
Taking on the role of ‘doula midwife’	Immersing the self into work ideology	
Taking in the medical views		
Making best of the organisational resources	Enacting the midwifery role whenever possible	Engaging Strategies
Eschewing the medical protocols		
Building alliance with women	Building alliance with women	
Shaping the organisational context	Shaping the organisational context	
Retaining both of the internal and external definitions of the midwife	Hybrid Identity	Hybrid Identity
Taking on the external definition of the midwife		
Taking in the external definition of the midwife		
Resisting the external definition of the midwife		
Internalising the internal definition of the midwife		

APPENDIX H: ETHICAL APPROVAL

H1 Ethical Approval from the University of Edinburgh

H2 Ethical Approval from Hangzhou Normal University in China

H1 Ethical Approval from the University of Edinburgh

Mail :: Inbox: Re: application for ethics in Nursing Studies页码, 1/2

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Date: Tue, 12 Oct 2010 21:37:50 +0100 [12/10/2010 21:37:50 BST]

From: Kath Melia <Kath.Melia@ed.ac.uk>

To: Jing Zhang <J.Zhang-26@sms.ed.ac.uk>

Cc: "rmander@staffmail.ed.ac.uk" <rmander@staffmail.ed.ac.uk>, Elaine Haycock-Stuart <e.a.haycock-stuart@ed.ac.uk>, Lorna Sheal <L.Sheal@ed.ac.uk>

Subject: Re: application for ethics in Nursing Studies

Headers: Show All Headers

Dear Jing,

Many thanks for sending your proposal for ethical review. It is an interesting study and I wish you well with it.

I am pleased to say that this can be approved and that you have completed the form in a way which meets the School requirements. There are no outstanding matters to attend to.

It is worth bearing in mind that the ethical aspect of research is an ongoing business and a matter for you to keep under review as you progress through your study. Your supervisors are aware of this and will provide guidance should any unforeseen matters arise.

Good luck with your research.

yours

Kath Melia
Professor of Nursing Studies

[Lorna, could you file this for the records, thanks Kath]

Jing Zhang wrote:

[Hide Quoted Text]

<https://www.sms.ed.ac.uk/imp/message.php?index=892>2010-10-20

Mail :: Inbox: Re: application for ethics in Nursing Studies页码, 2/2

Dear Prof. Melia

Many thanks for your time.

My name is Jing Zhang, PhD student in Nursing Studies. My supervisors are Dr. Elaine Haycock-Stuart and Prof. Rosemary Mander.

I have passed first year review and have discussed with my supervisors about ethical application and the application materials I prepared. They both agree I can apply for the level 2 ethics approval.

Lorna suggested me to submit the electronic application files to you as you are the representative of Nursing Studies in School Ethical Committee.

I attached the application form, information sheet, informed consent form and proposal. If you need the hard copy, please let me know. I will bring them to your office.

I really appreciate your time and kind help.

Best wishes,

Jing

--

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University of Edinburgh
School of Health is Social Science
RESEARCH AND RESEARCH ETHICS COMMITTEE
Ethical review form for level 2 and level 3 auditing



This form should be used for any research projects carried out under the auspices of SHSS that have been identified by self-audit as requiring detailed assessment - i.e. level 2 and level 3 projects under the three-tier system of ethical approval that has been developed by the Research Ethics Committee of the School. The levels within the system are explained in the SHSS Research Ethics Policy and Procedures document. Please indicate which level applies to your research.

This form provides general School-wide provisions. Proposers should feel free to supplement these with detailed provisions that may be stipulated by research collaborators (e.g. NHS) or professional bodies (e.g. BSA, SRA). The signed and completed form should be submitted, along with a copy of the research proposal, research instruments and information and consent sheets to the relevant person (Subject Area Research Ethics Co-ordinator for staff, postdoctoral fellows and postgraduate students, Dissertation supervisor for undergraduate student projects;). Level 3 requests should also be lodged, (if possible electronically) with the School Research Ethics Administrator for forwarding to the Research Ethics Committee.

Research Ethics Committee will monitor level 2 proposals yearly to satisfy themselves that the School Ethics Policy and Procedures are being complied with. They will revert to proposers in cases where there may be particular concerns of queries. For level 2 and 3 audits, work should not proceed until issues raised have been considered, by the appropriate people. Level 3 applications should be submitted well in advance of a required date of approval (see submission dates on shared area address).

The form developed by the College of Humanities and Social Science will be used for level 2 and 3 reviews. If the answer to any of the questions below is 'yes', please give details of how this issue is being/will be addressed to ensure that ethical standards are maintained.

1 THE RESEARCHERS		
Your name and position	Jing Zhang	PhD student
Proposed title of research	Study on the Professional Role and Identity of the Qualified Midwife in the Mainland of China	
Funding body	The University of Edinburgh	
Time scale for research	09/2009-09/2012	
List those who will be involved in conducting the research, including names and positions (e.g. 'PhD student')	Jing Zhang	PhD student
2 RISKS TO, AND SAFETY OF, RESEARCHERS		
Those named above need appropriate training to enable them to conduct the proposed research safely and in accordance with the ethical principles set out by the College	Yes/No	

SHSS Research Ethics: Procedures

Researchers are likely to be sent or go to any areas where their safety may be compromised, or they may need support to deal with difficult issues.	Yes/No	
Could researchers have any conflicts of interest?	Yes/No	
3 RISKS TO, AND SAFETY OF, PARTICIPANTS		
Could the research induce any psychological stress or discomfort?	Yes/No	The conflict between the expectation and reality of midwives' practice or women's experience may disturb or upset the participants. If participants become upset at the memory of an unpleasant experience, the researcher would ask respondents if they need to pause until they are feeling better. They will be offered psychological support by the researcher and be assured that they have the right to decide not to talk or terminate the interview.
Does the research involve any physically invasive or potentially physically harmful procedures?	Yes/No	
Could this research adversely affect participants in any other way?	Yes/No	
4 DATA PROTECTION		
Will any part of the research involve audio, film or video recording of individuals?	Yes/No	All participants will be asked for approval to record the interview. The whole process will be in anonymity and written and electronic resources will be guaranteed to be in a safe location.
Will the research require collection of personal information from any persons without their direct consent?	Yes/No	
How will the confidentiality of data, including the identity of participants (whether specifically recruited for the research or not) be ensured?		All participants will be given pseudonyms. The whole process will be in anonymity. The data and any information related to the participants will be guaranteed secure for personal information and will not be traced back to them in reports, presentations and other type of dissemination.
Who will be entitled to have access to the raw data?		Only the researcher (Jing Zhang) and the supervisors (Elaine haycock-Stuart

		and Rosemary Mander) can access to the data.
How and where will the data be stored, in what format, and for how long?		The data will be stored in written and electronic formats. These resources will be guaranteed to be in a safe location (the researcher's locked drawer and encrypted computer). After the study, the information will be destroyed properly.
What steps have been taken to ensure that only entitled persons will have access to the data?		1 The written data will be kept in the researcher's office drawer, which will be locked and be only accessible to the researcher. 2 The electronic data will be stored in the researcher's personal computer, which will be encrypted properly. The computer will be protected by updated Antivirus software.
How will the data be disposed of?		The written data will be destroyed through shredder and the electronic data will be permanently deleted after the study.
How will the results of the research be used?		The finding of the research will be used for research purposes only. It will be disseminated for PhD thesis, in professional seminar, conference and publications.
What feedback of findings will be given to participants?		Transcripts of the interviews and the final results of the study will be given to participants for their feedback.
Is any information likely to be passed on to external companies or organisations in the course of the research?	Yes/No	<input type="checkbox"/>
Will the project involve the transfer of personal data to countries outside the European Economic Area?	Yes/No	<input type="checkbox"/>
5 RESEARCH DESIGN		
The research involves living human subjects specifically recruited for this research project	Yes/No	<input type="checkbox"/>
If 'no', go to section 6		
How many participants will be involved in the study?	300	Questionnaire survey
	20	Interview
What criteria will be used in deciding on inclusion/exclusion of participants?	Midwives	Qualified midwives in the Mainland of China
	Women clients	Women clients in the Mainland of China who have underwent normal

		delivery by qualified midwife
How will the sample be recruited?	Quantitative phase	Convenience sample will be drawn from the midwife members of Chinese Midwives Coalition (CMC) website with the consent by the manager of the website and participants themselves.
	Qualitative phase	Follow-up participants from quantitative phase will be selected by purposive sampling. Theoretical sample (both midwives and women clients) drawn from participants in quantitative phase and non-CMC members (with help of the participants)
Will the study involve groups or individuals who are in custody or care, such as students at school, self help groups, residents of nursing home?	Yes/No	<input type="checkbox"/>
Will there be a control group?	Yes/No	<input type="checkbox"/>
What information will be provided to participants prior to their consent? (e.g. information leaflet, briefing session)		Information notice (including the research aims, design, possible publication and the information of the researcher) will be posted on the homepage of CMC website and to the participants' email address
Participants have a right to withdraw from the study at any time. Please tick to confirm that participants will be advised of their rights, including the right to continue receiving services if they withdraw from the study..	<input checked="" type="checkbox"/>	
Will it be necessary for participants to take part in the study without their knowledge and consent? (e.g. covert observation of people in non-public places)	Yes/No	<input type="checkbox"/>
Where consent is obtained, what steps will be taken to ensure that a written record is maintained?		The informed consent form will be sent to participants' email address, signed by the participants and emailed back to the researcher
In the case of participants whose first language is not English, what arrangements are being made to ensure informed consent?		This study will be conducted in the Mainland of China. All the related documents will be translated into Chinese, back translated and checked by a bilingual midwifery expert.

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Will participants receive any financial or other benefit from their participation?	<input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No	Participants will receive small gifts (costing less than 5 pounds) from the researcher for the gratitude of their participation and the final result of this study.
Are any of the participants likely to be particularly vulnerable, such as elderly or disabled people, adults with incapacity, your own students, members of ethnic minorities, or in a professional or client relationship with the researcher?	<input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No	
Will any of the participants be under 16 years of age?	<input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No	
Do the researchers named above need to be cleared through the Disclosure/Enhanced Disclosure procedures?	<input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No	
Will any of the participants be interviewed in situations which will compromise their ability to give informed consent, such as in prison, residential care, or the care of the local authority?	<input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No	
6 EXTERNAL PROFESSIONAL BODIES		
Is the research proposal subject to scrutiny by any external body concerned with ethical approval?	<input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No	
If so, which body?		Hangzhou Normal University in China Chinese Midwives Coalition Website
Date approval sought		June, 29 th , 2010
Outcome, if known <i>or</i>		Approval
Date outcome expected		July, 29 th , 2010
7 ISSUES ARISING FROM THE PROPOSAL		
In my view, ethical issues have been satisfactorily addressed <input checked="" type="checkbox"/> OR		
In my view, the ethical issues listed below arise and the following steps are being taken to address them:		
Signature	Jing zhang.	
Date	20/0. 9. 20.	

H2 Ethical Approval from Hangzhou Normal University in China

科研课题伦理申请表

1 研究者信息	
姓名	张晶
课题名称	中国注册助产士专业身份的研究
单位及职位	中国杭州师范大学护理学院，讲师 英国爱丁堡大学社会健康学院，博士研究生
课题起始时间	09/2009-09/2012
2 课题研究对研究者的潜在危险	
此项课题的研究环境是否会对研究者的安全造成威胁？	是/否
3 课题研究对研究对象的潜在危险	
此项课题是否会令研究对象产生任何不良情绪或心理反应？	是/否 在访谈过程中，助产工作中理想与现实的差距，可能会令研究对象产生不良的心理反应。 解决措施：在访谈过程中，如果研究对象在回忆某些不开心的经历时产生不良的情绪反应，研究者可征求研究对象是否需要时间调整情绪。同时，研究者需再次告知研究对象，他/她有权选择回答研究者的问题或终止本次访谈。如必要，研究者将提供适当心理疏导，或为其邀请专业心理咨询师进行心理疏导。
此项课题研究过程中，是否包含任何侵入性操作，或对研究对象的身体存在潜在的伤害？	是/否
此项课题是否会对研究对象产生其他的负面影响？	是/否
4 研究数据的保护	
研究过程中是否需要使用音频或视频记录研究数据？	是/否 本研究需在征得研究对象同意后，对访谈过程全程录音。录音资料采取匿名处理，书面及电子版原始资料将严格保密。
在此项研究中，所需研究对象个人信息的获取，是否有未经研究对象直接同意的情况存在？	是/否
如何确保研究数据的保密性？（包括研究对象真实身份）	研究对象的个人信息采取匿名处理。原始资料严格保密。与研究对象相关

	的任何个人数据和信息将确保安全，并保证本研究结果在公开发表时，不会泄露研究对象的个人信息，也不会因此追溯回研究对象本人。
原始数据的审阅权限？	仅研究者本人（张晶）和研究者的导师（Dr Elaine Haycock-Stuart and Prof. Rosemary Mander）有权审阅原始数据。
数据如何保存？以何种形式保存？保存时间？	数据以文字版和电子版形式保存，并确保存放于安全地点（研究者本人加锁的文件柜以及加密的计算机内）。博士课程结束后，原始资料将会妥善销毁。
研究者采取何种措施以确保数据的安全性？	文字版原始数据将存放于研究者本人加锁的文件柜内，只有研究者本人持有钥匙。 电子版原始数据将保存在研究者加密的私人计算机内。计算机内杀毒软件定期更新，以保证数据的安全性。必要时，请IT人士帮忙维护。
数据最终如何处理？	博士学位完成后，文字版原始数据用碎纸机销毁；电子版原始数据从电脑内永久删除。
研究结果将如何使用？	本研究的结果仅供研究使用。经过匿名处理的研究结果将在研究者的博士论文、专业研讨会、会议以及期刊上公开发表。
研究结果以何种形式和内容反馈给研究对象？	访谈录音的逐字稿以及研究最终结果将反馈给研究对象。
5 研究设计	
此项研究是否以人作为研究对象？如果‘否’见6项	是/否
此项研究需要多少例研究对象？	预计 20 个访谈对象 因为本研究采用质性研究扎根理论研究方法，确切的研究对象数目需要在通过具体研究确认，直到研究者所得的信息达到饱和后，方可终止纳入新的研究对象。
研究对象的纳入标准是什么？	注册助产士 纳入标准： 1) 研究开始时，在杭州从事助产工作的助产士； 2) 并完成正规国家助产或护理课程教育； 3) 并经浙江省卫生厅批准执业，具有助产执业资格。

2

如何进行抽样?	<p>基于扎根理论, 研究初始采用立意抽样法进行抽样以确定初始研究对象, 随后按照理论抽样法进一步深入抽样。</p> <p>考虑到入选过程中, 如果通过医院管理本门推荐, 研究对象可能被动参与研究, 不但涉及伦理问题, 而且会影响研究结果的可信度。因此, 研究者计划尽量通过个人关系纳入研究对象。</p> <p>对于只能通过产科护士长或医院领导层引见的助产士, 研究者需采取更多措施以建立与研究对象间的信任关系, 如强调研究的匿名性和保密性, 并在访谈时间和地点的选择上, 尽量满足研究对象的要求。</p>
此项研究有无对照组?	是/否
研究者是否告知研究对象, 他、她有权在研究进行过程中的任一时间选择退出本研究(包括让研究对象明确, 即使选择退出研究, 其相关利益也不会受到任何伤害)。	是/否
此项研究是否需要研究对象进行盲查?(如: 在非公共场所, 在研究对象不知情下, 对其进行观察)	是/否
此项研究的知情同意过程如何以书面形式保存?	<p>在进行访谈前, 研究者将会向所有研究对象出示知情同意书, 并进行详细解释。研究对象在充分理解知情同意书中所列事项后, 要求在知情同意书上签字。研究者和研究对象将各自妥善保存知情同意书的副本。</p>
研究对象是否会因为参加此项研究而获得任何物质或其他形式的好处?	是/否
研究对象中是否存在弱势群体, 如老人, 残疾人, 研究者的学生, 少数民族或与研究者相关的专业人员或病人?	是/否

	<p>与否, 不会为其带来任何负面影响。研究者需采取更多措施以建立与研究对象间的信任关系, 如强调研究的匿名性和保密性, 并在访谈时间和地点的选择上, 尽量满足研究对象的要求。</p>
研究对象的年龄是否低于16岁?	是/否
6 其他专业伦理审核	
此项研究计划是否通过其他相关研究机构或部门的伦理审查?	是/否
如果是, 请列出。	英国爱丁堡大学社会健康学院伦理委员会
审查结果	通过
日期	2010年10月12日
7 研究计划中所出现的伦理问题	
<p>此项研究已充分考虑了研究中可能出现的伦理问题, 这些伦理问题可通过采取以上措施妥善处理。</p>	
研究者签字	张 明
日期	2010. 10. 20
8 审批结果	
负责人签字	叶高翔
日期	

APPENDIX I: STUDY INFORMATION SHEET

I1 Letter to Hospital Manager

I2 Letter to Healthcare Centre Manager

I3 Study Information Sheet for Midwife Participant

I4 Study Information Sheet for Woman Participant

I1 Letter to Hospital Manager (Chinese Version)

中国注册助产士专业身份的研究

参与研究申请书



尊敬的医院相关负责人您好,

本研究是英国爱丁堡大学社会健康学院的博士研究课题。由博士研究生张晶 (Zhang Jing) 在 Elaine Haycock-Stuart 博士以及 Rosemary Mander 教授的指导下进行。本研究旨在通过与注册助产士的半结构性访谈, 探讨中国助产士对其专业身份的认知现状, 并进一步识别影响助产士身份认知的相关因素。本研究结果将有助于弥补中国助产士专业身份研究的缺失, 可为中国助产专业的政策制定提供依据, 进而提高助产士工作效能, 促进助产专业化发展。

本研究已经爱丁堡大学伦理委员会及杭州师范大学学术委员会审查小组审查通过。可请准予此研究于贵单位进行, 贵单位助产人员符合研究对象者, 将被邀请与研究者优先进行面对面的会谈, 会谈地点及时间由会谈双方共同决定, 并以受访对象的要求为优先考虑。访谈时间约 1 小时, 会谈在访谈对象下班后进行, 不会影响贵单位工作的正常运行。会谈全程录音并转录为逐字文字稿。所附研究说明书将发给助产士, 如其同意参与本项研究, 需与访谈开始前, 签署知情同意书。

访谈过程中所获得的原始信息均将绝对保密, 并进行匿名处理。纸质以及电子数据均确保存放于安全的地方。会谈中所取得的资料仅研究者及其指导教授可以使用。所有的个人信息都不会在会谈文稿或提出发表时被确认。所有原始资料将在博士课题结束后妥善销毁。

最后, 再次向您对本研究提供的大力支持致以诚挚的谢意。

此致

敬礼

爱丁堡大学社会健康学院博士班学生
张晶敬上

I1 Letter to Hospital Manager (English Version)



Dear Manager,

My name is Jing Zhang, a doctoral student at the University of Edinburgh, U.K. My research aims to gain a better understanding of the professional identity construction of the qualified midwives in hospital settings. It focuses on exploring how midwives construct their

professional identity in the contemporary maternity care system and further identifying the factors that influence the process. It is hoped that the findings from this study will contribute to the growing body of knowledge on how midwives construct their professional identity and could further help clarify the ambiguous professional identity in order to enhance midwives' efficacy and willingness to cope with the external barriers inhibiting midwifery development.

I am writing to request permission to conduct face-to-face interviews with qualified midwives working in your facility. The interviews will be conducted at a convenient venue and time that are suitable for the participants. The interviews will be audio-taped and transcribed. The attached *information sheet* will be given to midwives who are willing to participate. The participants will then be asked to sign a consent form if they agree to take part.

All information obtained during the interviews, including the name of your facility, will be held confidentially and anonymously. Written and electronic data is guaranteed to be in a safe location. Only the researcher and the supervisors are allowed to have access to the data. Identifying information about your staff and the name of your facility will not be traced back to you in reports, presentations or other types of dissemination. The raw data will be destroyed properly after the whole study is deemed completed.

Thank you for your time and consideration.

Yours faithfully

Jing Zhang

I2 Letter to Healthcare Centre Manager (Chinese Version)

中国注册助产士专业身份的研究 参与研究申请书



尊敬的社区相关负责人您好,

本研究是英国爱丁堡大学社会健康学院的博士研究课题。由博士研究生张晶 (Zhang Jing) 在 Elaine Haycock-Stuart 博士以及 Rosemary Mander 教授的指导下进行。本研究旨在通过与医院注册助产士和产妇的半结构式访谈, 探讨助产士对其专业身份的认知现状以及产妇对于助产士群体及助产服务的认可情况。本研究结果将有助于促进助产专业发展, 进而有助于为母婴提供高质量的助产服务。

本研究已经爱丁堡大学伦理委员会及杭州师范大学学术委员会审查小组审查通过。可请准予此研究于贵单位进行, 贵单位服务对象符合研究条件者, 将被邀请与研究者优先进行面对面的会谈, 会谈地点及时间由会谈双方共同决定, 并以受访对象的要求为优先考虑。访谈时间约 1 小时。会谈全程录音并转录为逐字文字稿。所附研究说明书将发给产妇, 如其同意参与本项研究, 需与访谈开始前, 签署知情同意书。

访谈过程中所获得的原始信息均将绝对保密, 并进行匿名处理。纸质以及电子数据均确保存放于安全的地方。会谈中所取得的资料仅研究者及其指导教授可以使用。所有的个人信息都不会在会谈文稿或提出发表时被确认。所有原始资料将在博士课题结束后妥善销毁。

最后, 再次向您对本研究提供的大力支持致以诚挚的谢意。

此致

敬礼

爱丁堡大学社会健康学院博士班学生
张晶敬上

I2 Letter to Healthcare Centre Manager (English Version)

Dear Manager,



My name is Jing Zhang, a doctoral student at the University of Edinburgh, U.K. My research aims to gain a better understanding of the professional identity construction of the qualified midwives in hospital settings. It focuses on exploring how midwives construct their professional identity in the contemporary maternity care system and further identifying the factors that influence the process. It is hoped that the findings from this study will help promote midwifery development and provide mothers and babies with the high quality of maternity service.

I am writing to request permission to conduct face-to-face interviews with the women clients who are under your services in the community. The interviews will be conducted at a convenient venue and time that are suitable for the participants. The interviews will be audio-taped and transcribed. The attached *information sheet* will be given to women who are willing to participate. The participants will then be asked to sign a consent form if they agree to take part.

All information obtained during the interviews, including the name of your facility, will be held confidentially and anonymously. Written and electronic data is guaranteed to be in a safe location. Only the researcher and the supervisors are allowed to have access to the data. Identifying information about the participants and the name of your facility will not be traced back to you in reports, presentations or other types of dissemination. The raw data will be destroyed properly after the whole study is deemed completed.

Thank you for your time and consideration.

Yours faithfully

Jing Zhang

中国医院助产士专业身份建构的研究

研究说明书



各位助产同仁您好，

本研究是英国爱丁堡大学社会健康学院的博士研究课题。由博士研究生张晶（Zhang Jing）在 Elaine Haycock-Stuart 博士以及 Rosemary Mander 教授的指导下进行。您将被邀请参加此项研究，分享您的助产工作经验以及您对助产士专业身份的看法。本研究结果将有助于提高大众对于助产工作的认可，促进助产专业发展，进而有助于为母婴提供高质量的助产服务。本知情同意书提供的研究相关信息，可帮助您决定是否参加此项研究。请您仔细阅读以下信息，如有任何疑问请向负责该项研究的研究者提出。

什么是专业身份？

专业身份是助产士自己及社会他人对“助产士是谁”的理解，是助产士所赋予自己的以及被别人所赋予的各种意义。换言之，专业身份将助产士置于社会系统中，给自我理解以结构和内容。它既包括助产士个人及助产士群体对“助产士是谁”的理解，强调个体的独特性及自我反思的过程，是助产士专业身份的内在属性；也包括社会他人对“助产士”的认识，关注个体与社会之间的互动，涉及政策、制度、文化传统所赋予助产士的角色。

为什么要进行此项研究？

本研究旨在通过与注册助产士的半结构式访谈，探讨中国医院助产士对其专业身份的认知现状，并进一步识别影响助产士身份认知的相关因素。本研究结果将有助于弥补中国助产士专业身份研究的缺失，可为中国助产专业的政策制定提供依据，进而提高助产士工作效能，促进助产专业化发展。

为什么选择我参加？

本研究旨在探讨助产士对于自身专业身份的认知情况，基于您的助产工作经验以及您对助产专业、助产士专业身份的看法。您的参与对于本人博士课题的研究以及中国助产发展都具有非常深远的意义。

我必须参加吗？

您可依照自己的意愿选择参加或拒绝参加此项研究。如果您确定参加本研究，请您保存好此研究计划书，并在后面附带的知情同意书上签字。在研究过程中，您可在任何时间、无条件退出本研究，您的选择不会对您的权益造成任何影响。

如果参加，我需要做什么？

您将被邀请分享您的助产工作经验以及您对助产专业、助产士专业身份的看法。研究采用面对面的会谈方式进行，持续约 1 小时左右。在会谈中，会谈内容将被录音，以保证访谈过程中收集资料的完整性。您有权拒绝回答研究者提出的任何问题，也可要求关闭录音设备，或者终止访谈。

会谈的详细内容将会以书面资料形式呈现，若有需要将会与您联络第二次会谈，再次会谈旨在确认书面资料是否完全呈现出您的工作经验及对助产专业身份的看法和想法。

我提供的信息会怎样处理？

访谈过程中所获得的原始信息均将绝对保密，并进行匿名处理。纸质以及电子数据均确保存放于安全的地方。会谈中所取得的资料仅研究者及其指导教授可以使用。所有的个人信息都不会在会谈文稿或提出发表时被确认。所有原始资料将在博士课题结束后妥善销毁。

我能知道研究结果吗？

如果您对本研究感兴趣，研究结束时，我会将研究结果以邮寄或电子邮件形式发送给您。

我现在要做什么？

如果您同意参加本研究，您将被邀请参加会谈。会谈之前，需要您签署以下知情同意书。

感谢您参与本研究，请确认您已详细阅读并了解以上相关的讯息。如果您有任何与本课题相关的问题，请与我联系。我的联系信息如下：

研究者联系信息（英国）

Jing Zhang

PhD student

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

电话: 0044-07788813401

研究者联系信息（中国）

张晶

讲师

助产生育护理研究所成员

护理学院

杭州师范大学

电话: 0086 12599021100

若您希望与研究者的指导教授联络，以下是她们的联系方式：

第一导师联系信息：

Dr. Elaine Haycock-Stuart

Senior Lecturer

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

电话: 0044-0131 650 8442

第二导师联系信息：

Prof. Rosemary Mander

Emeritus Professor of Midwifery

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

电话: 0044-0131 650 3896

最后，再次对您的参与及合作致以诚挚的谢意。

此致

敬礼

爱丁堡大学社会健康学院博士班学生
张晶敬上

I3 Study Information Sheet for Midwife Participant (English Version)

Study Information Sheet

Hospital-based Chinese Midwives' Professional Identity Construction



Dear midwife,

My name is Jing Zhang, a doctoral student at the University of Edinburgh, U.K. I would like to invite you to take part in my Nursing Studies doctoral research. The long-term significance of the study could help increase public understanding of midwifery, promoting midwifery development and eventually benefiting mothers and babies. Before you decide, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is professional identity ?

Professional identity is described here as the knowledge, beliefs and attributes of being a professional that are internalised into members within the professional group, related to how professionals compare and differentiate themselves from other professional group members and associated with the professional role being undertaken by the individual. Professional identity consists of professionals' perceptions of 'who I am' and emphasises individuality and reflectivity, which is its internal attributes. Meanwhile, it also involves the perspectives from social others, concerning the interaction among individual, society and culture, regarding the professional role designated by policy, institution and culture.

Why is this study being carried out?

This study aims to gain a better understanding of the professional identity construction of the qualified midwives in hospital settings. It focuses on exploring how midwives construct their professional identity in the contemporary maternity care system and further identifying the factors that influence the process.

This research will culminate in a written report, which will be submitted in partial fulfilment for the degree of PhD of Nursing Studies at the University of Edinburgh. It is hoped that the findings from this study will contribute to the growing body of knowledge on how midwives conceptualise their professional identity, which could help clarify the ambiguity within the profession and further enhance midwives' efficacy and willingness to cope with the external barriers inhibiting midwifery development.

Why have I been chosen?

This study aims to gain a better understanding of the professional identity construction of the qualified midwives in hospital settings, which is based on your perspectives in terms of your working experience. Your taking part means a lot to the future of midwifery and to my doctoral study.

Do I have to take part?

You can decide whether or not you want to take part. If you do decide to participate, you will be given this information sheet to keep and you will be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time without giving a reason. A decision to withdraw at any time or a decision not to participate will not affect your rights.

What will happen if I take part?

If you decide to take part in this study, you will be invited to participate in a face-to-face, tape-recorded interview lasting about one hour in duration. You may decline to answer any question and may ask me to turn off the tape recorders if you wish.

A follow up interview to clarify the specific meaning of some points raised in the interview may be held.

What will happen to the information that I give?

All information obtained during the interview will be kept confidentially and anonymously. Written and electronic data is guaranteed to be kept in a safe location. Only the researcher and the supervisors are allowed to have access to the raw data. Your personal information will not be traced back to you in reports, presentations or any other type of dissemination. The raw data will be destroyed properly after the whole study is deemed completed.

Can I know about the results of the study?

If you are interested in the study, you can be updated about the findings of the study when it is completed.

What do I do now?

If you would like to take part, I would be grateful if you complete and sign the enclosed informed consent form.

If you have any inquiries regarding this research project, I would be happy to discuss them with you. My contact details are below:

Researcher Contact Details (in the UK)

Jing Zhang

PhD student, Nursing Studies
Medical School, Teviot Place
School of Health in Social Science
University of Edinburgh
Tel No: 0044-07788813401

Researcher Contact Details (in China)

Jing Zhang

Lecturer
Nursing School
Hangzhou Normal University
Tel No: 0086-0571-28865347

If you wish to speak to my supervisors, here are their contact details:

Principal Supervisor Contact Details

Dr. Elaine Haycock-Stuart

Senior Lecturer

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

Tel No: 0044-0131 650 8442

Second Supervisor Contact Details

Prof. Rosemary Mander

Emeritus Professor of Midwifery

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

Tel No: 0044-0131 650 3896

Thank you for your time and consideration.

Yours sincerely

Jing Zhang

中国医院助产士专业身份建构的研究

研究说明书



各位新妈妈您好，

本研究是英国爱丁堡大学社会健康学院的博士研究课题。由博士研究生张晶（Zhang Jing）在 Elaine Haycock-Stuart 博士以及 Rosemary Mander 教授的指导下进行。您将被邀请参加此项研究，分享您的分娩经验以及您对助产士及助产服务的看法。本知情同意书提供的研究相关信息，可帮助您决定是否参加此项研究。请您仔细阅读以下信息，如有任何疑问请向负责该项研究的研究者提出。

为什么要进行此项研究？

本研究旨在通过与注册助产士和产妇的半结构式访谈，探讨助产士对其专业身份的认知现状以及产妇对于助产士群体及助产服务的认可情况。本研究结果将有助于促进助产专业发展，进而有助于为母婴提供高质量的助产服务。

为什么选择我参加？

本研究探讨产妇对于助产士群体及助产服务的认可情况。基于您孕期及分娩经历的描述和回顾，来阐述您对助产专业、助产士专业身份的看法。您的参与对于本人博士课题的研究以及产科服务都具有非常深远的意义。

我必须参加吗？

您可依照自己的意愿选择参加或拒绝参加此项研究。如果您确定参加本研究，请您保存好此研究计划书，并在后面附带的知情同意书上签字。在研究过程中，您可在任何时间、无条件退出本研究，您的选择不会对您的权益造成任何影响。

如果参加，我需要做什么？

您将被邀请分享您的孕期及分娩经历以及您对助产专业、助产士专业身份的看法。研究采用面对面的会谈方式进行，持续约 1 小时左右。在会谈中，会谈内容将被录音，以保证访谈过程中收集资料的完整性。您有权拒绝回答研究者提出的任何问题，也可要求关闭录音设备，或者终止访谈。

会谈的详细内容将会以书面资料形式呈现，若有需要将会与您联络第二次会谈，再次会谈旨在确认书面资料是否完全呈现出您的分娩经历及对助产服务的看法和想法。

我提供的信息会怎样处理？

访谈过程中所获得的原始信息均将绝对保密，并进行匿名处理。纸质以及电子数据均确保存放于安全的地方。会谈中所取得的资料仅研究者及其指导教授可以使用。所有的个人信息都不会在会谈文稿或提出发表时被确认。所有原始资料将在博士课题结束后妥善销毁。

我能知道研究结果吗？

如果您对本研究感兴趣，研究结束时，我会将研究结果以邮寄或电子邮件形式发送给您。

我现在要做什么？

如果您同意参加本研究，您将被邀请参加会谈。会谈之前，需要您签署以下知情同意书。

感谢您参与本研究，请确认您已详细阅读并了解以上相关的讯息。如果您有任何与本课程相关的问题，请与我联系。我的联系信息如下：

研究者联系信息（英国）

Jing Zhang

PhD student

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

电话: 0044-07788813401

研究者联系信息（中国）

张晶

讲师

助产生育护理研究所成员

护理学院

杭州师范大学

电话: 0086 15599021100

您若希望与研究者的指导教授联络，以下是她们的联系方式。

第一导师联系方式（英国）：

Dr. Elaine Haycock-Stuart

Senior Lecturer

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

Tel No: 0044-0131 650 8442

第二导师联系方式（英国）：

Prof. Rosemary Mander

Emeritus Professor of Midwifery

Medical School, Teviot Place

School of Health in Social Science

University of Edinburgh

Tel No: 0044-0131 650 3896

谢意

此致

敬礼

爱丁堡大学社会健康学院博士班学生
张晶敬上

I4 Study Information Sheet for Woman Participant (English Version)

Study Information Sheet

Hospital-based Chinese Midwives' Professional Identity Construction



Dear new mother,

My name is Jing Zhang, a doctoral student at the University of Edinburgh, U.K. I would like to invite you to take part in my Nursing Studies doctoral research. Before you decide, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Why is this study being carried out?

This study aims to gain a better understanding of the professional identity construction of the qualified midwives in hospital settings. It focuses on exploring how midwives perceive their professional identity as well as their women clients' views on midwifery care.

This research will culminate in a written report, which will be submitted in partial fulfilment for the degree of PhD of Nursing Studies at the University of Edinburgh. It is hoped that the findings from this study will help promote midwifery development and provide mothers and babies with the high quality of maternity service.

Why have I been chosen?

This study is aiming to explore professional identity construction of the qualified midwives in hospital settings. As the significant service user, your perspectives of midwives in terms of your childbirth experiences are of great importance to the study. Your taking part means a lot to the future of midwifery and to my doctoral study.

Do I have to take part?

You can decide whether or not you want to take part. If you do decide to participate, you will be given this information sheet to keep and you will be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time without giving a reason. A decision to withdraw at any time or a decision not to participate will not affect your rights or any care/treatment that you are offered

What will happen if I take part?

If you decide to take part in this study, you will be invited to participate in a face-to-face, tape-recorded interview lasting about one hour in duration. You may decline to answer any question and may ask me to turn off the tape recorders if you wish. A follow up interview to clarify the specific meaning of some points raised in the interview may be held.

What will happen to the information that I give?

All information obtained during the interview will be kept confidentially and anonymously. Written and electronic data is guaranteed to be kept in a safe location. Only the researcher and the supervisors are allowed to have access to the raw data. Your personal information will not be traced back to you in reports, presentations or any other type of dissemination. The raw data will be destroyed properly after the whole study is deemed completed.

Can I know about the results of the study?

If you are interested in the study, you can be updated about the findings of the study when it is completed.

What do I do now?

If you would like to take part, I would be grateful if you complete and sign the enclosed informed consent form.

If you have any inquiries regarding this research project, I would be happy to discuss them with you. My contact details are below:

Researcher Contact Details (in the UK)

Jing Zhang

PhD student, Nursing Studies
Medical School, Teviot Place
School of Health in Social Science
University of Edinburgh
Tel No: 0044-07788813401

Researcher Contact Details (in China)

Jing Zhang

Lecturer
Nursing School
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Second Supervisor Contact Details

Prof. Rosemary Mander

Emeritus Professor of Midwifery
Medical School, Teviot Place
School of Health in Social Science
University of Edinburgh
Tel No: 0044-0131 650 3896

Thank you for your time and consideration.

Yours sincerely

Jing Zhang

Appendix J: Informed Consent Form

J1 Informed Consent Form to Midwife Participants

J2 Informed Consent Form to Women Participants

J1 Informed Consent Form to Midwife Participants (Chinese Version)

**中国医院助产士专业身份建构的研究
知情同意书**

本人同意参与此研究课题，本人的同意基于对以下所述的了解：

- 1) 本人已经阅读并了解研究说明书所提供的讯息，并且有机会向研究者提出问题，所有问题均已得到解答。本人同意会谈的文稿、录音以及所有书面资料仅提供为此研究使用。 ☐
- 2) 本人了解参加此项研究完全基于个人意愿，本人有权在任何时间无条件退出，并且不会因此而导致相关权益受到影响。 ☐
- 3) 本人了解此项研究中研究者所获取的我的个人信息将严格保密并进行匿名处理，不会在会谈文稿或提出发表时被确认。 ☐
- 4) 本人了解此项研究结束后，所有原始数据均会妥善销毁。 ☐
- 5) 本人同意参与会谈，并允许对访谈全程进行录音。本人也了解基于研究需要，可能需要第二次的会面，以确认前次会谈的书面资料是否完全呈现出我的看法及想法。 ☐
- 6) 本人同意参与以上研究。 ☐

调查对象姓名（打印）

日期

签名

我已准确地将这份文件告知调查对象，他/她准确地阅读了这份知情同意书，并证明该调查对象有机会提出问题。我证明他/她是自愿同意的。

研究者姓名（打印）

日期

签名

请将此‘知情同意书’交给研究者，并请保留一份签过字的‘知情同意书’副本

J1 Informed Consent Form to Midwife Participants (English Version)

Informed Consent Form

**Hospital-based Chinese Midwives' Professional Identity
Construction**

Consent to participation

- 1) I have read and understood the study information sheet for the above project ☐

and any doubts and questions have been clarified.

- 2) I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason and without any adverse effects. ☐
- 3) I understand that all information taken by the researcher during the process of the study will be treated confidentially and anonymously. ☐
- 4) I understand that the data collected will be carefully destroyed after the study is completed. ☐
- 5) I agree to participate in the interview tape-recorded. I also understand the necessity for a follow-up interview for clarifying aspects of the previous interview. ☐
- 6) I agree to take part in the above study. ☐

Participant name (Print)	Date	Signature
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Researcher name (Print)	Date	Signature
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Please return the signed form to: Jing Zhang and keep one copy of this form for yourself.

J2 Informed Consent Form to Women Participants (Chinese Version)

**中国医院助产士专业身份建构的研究
知情同意书**

本人同意参与此研究课题，本人的同意基于对以下所述的了解：

- 1) 本人已经阅读并了解研究说明书所提供的信息，并且有机会向研究者提出问题，所有问题均已得到解答。本人同意会谈的文稿、录音以及所有书面资料仅提供为此研究使用。 ☐

- 2) 本人了解参加此项研究完全基于个人意愿，本人有权在任何时间无条件退出，并且不会因此而导致相关权益受到影响。 ☐
- 3) 本人了解此项研究中研究者所获取的我的个人信息将严格保密并进行匿名处理，不会在会谈文稿或提出发表时被确认。 ☐
- 4) 本人了解此项研究结束后，所有原始数据均会妥善销毁。 ☐
- 5) 本人同意参与会谈，并允许对访谈全程进行录音。本人也了解基于研究需要，可能需要第二次的会面，以确认前次会谈的书面资料是否完全呈现出我的看法及想法。 ☐
- 6) 本人同意参与以上研究。 ☐

调查对象姓名（打印） 日期 签名

我已准确地将这份文件告知调查对象，他/她准确地阅读了这份知情同意书，并证明该调查对象有机会提出问题。我证明他/她是自愿同意的。

研究者姓名（打印） 日期 签名

请将此‘知情同意书’交给研究者，并请保留一份签过字的‘知情同意书’副本

J2 Informed Consent Form to Women Participants (English Version)

Informed Consent Form

Hospital-based Chinese Midwives' Professional Identity

Construction

Consent to participation

- 1) I have read and understood the study information sheet for the above project and any doubts and questions have been clarified. ☐
- 2) I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason and without any adverse effects. ☐
- 3) I understand that all information taken by the researcher during the process of the study will be treated confidentially and anonymously. ☐
- 4) I understand that the data collected will be carefully destroyed after the study is completed. ☐
- 5) I agree to participate in the interview tape-recorded. I also understand the necessity for a follow-up interview for clarifying aspects of the previous interview. ☐
- 6) I agree to take part in the above study. ☐

_____	_____	_____
Participant name (Print)	Date	Signature

_____	_____	_____
Researcher name (Print)	Date	Signature

Please return the signed form to: Jing Zhang and keep one copy of this form for yourself.